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**SUBSTANCE-USING
MOTHERS:
TAKING CONTROL,
LOSING CONTROL**

**The Everyday Lives of
Drug and Alcohol-
Dependent Mothers in the
West Midlands**

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A thesis submitted for the qualification of PhD in Sociology

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Summary

There are now in Britain some 200,000 homes with a drug-using parent, and this figure does not include the homes with an alcohol-dependent parent. These levels of substance-use seem set to increase, particularly among women of childbearing age.

Research so far conducted indicates that women with substance problems are more reluctant than men to come forward for help, and this is especially the case if the women are mothers. Thus the study of the lives of substance-using mothers is an important area of concern, pragmatically in terms of social policy and sociologically in terms of studying a little-known, marginalised and vulnerable population. Despite this importance, little research has been conducted to date on the everyday experiences of substance-using mothers.

This thesis addresses this gap in knowledge by researching the lives of forty-eight women with substance-dependency problems, using a grounded-theory approach to analyse data gathered with the aid of a range of research instruments, including a series of semi-structured interviews. The research respondents were interviewed about their childhood experiences, the context of their daily lives as mothers and substance-users, their relationships with their children, and their attitudes and perceptions towards their substance-use.

The thesis argued that, in the everyday lives of substance-using mothers, a key narrative is that of taking and losing control, as the women struggle to maintain their family-lives in the face of disruptive forces. The women hold to traditional views of motherhood, and find themselves reluctant non-conformists to this ideal, as they share, together with other mothers under patriarchy, a sense of powerless responsibility for the wellbeing of their children. Substance-using mothers, it is argued, are an example of a conceptual category of 'problematic mothers' in that their failure to cope and protect their children effectively reveals some otherwise-hidden dimensions of normative motherhood.

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Dedication

My MA dissertation was dedicated to my son, Michael, born right in the middle of it. This thesis is dedicated to my daughter, Jasmine Grace, newly-born. It is also dedicated to the 48 sisters whose lives form the substance of this study.

Declaration

This thesis gained its initial impetus from a small-scale study of six heroin-using mothers in Coventry, who were interviewed in a single interview lasting approximately one hour each, in 1991-2. Some information from these women (pseudonyms Adele, Bernice, Clare, Diane, Elaine and Fiona) has been incorporated into this thesis.

Chapter One:

The Unanswered Questions on Substance-using Mothers' Daily Lives

Introduction

The existence of mothers who are dependent on psychoactive substances, and particularly illegal substances such as heroin, amphetamine, or cocaine, poses a problem for society. There are two related dimensions to this. The first is a pragmatic concern over the mothers' competence and childrearing ability. Those involved with the mother - her family, friends, neighbours, professionals charged with the task of protecting children, and indeed interested bystanders and occasionally the wider public via the media also - may wonder whether she is able to devote enough time to her children when she needs to obtain her drugs, whether she can give them enough attention, protection and practical nurturance, whether she can be an adequate role-model for them, and whether, in the final analysis, she loves her children enough. This concern is expressed primarily through legal and social services' policies and practices, such as granting Local Authorities a freeing order for adoption for the child of a persistent drug-user with a 'chaotic' lifestyle.

Alongside this pragmatic concern is a second dimension, which relates to the social understanding of the role or category of 'mother'. The category of mother has powerful resonances and, as will be shown in Chapter Four, is a primary or 'master status' (Becker, 1963a:33) which carries a heavy burden of socially-sanctioned responsibilities and expectations. To be simultaneously a mother and a substance-user - especially a 'junkie' or an alcoholic - has the effect of 'fracturing' the category of mother, breaking apart normative notions of selfless mother-love in a

way which is disturbing and challenging to our shared ideology of what a mother 'should be'.

This disturbing fracturing of the dominant paradigm of motherhood may in part account for the ferocity of punitive social and legal responses meted out to known drug-using mothers, who in the United States may be both imprisoned during pregnancy and lose their babies to foster-care at birth (for example, see Maher, 1992; Seigel, 1992; Peak and Del Papa, 1993; Beckett, 1995). In Britain, the response is more muted, but popular media accounts of drug-using mothers may resolve some of the discomfort felt at this fractured category of drug-using mother by emphasising the mother as actively culpable, in other words 'evil'. The 'evil mother' is a category to which substance-using mothers can be assigned, and it acts to resolve the tension by sealing off their deviance into a separate category, preserving intact the original category of 'mother'. Thus, for example, when a five-year-old child, Dillon Hull, was shot and killed apparently deliberately in a conflict over drug-debts in 1997, the media response was to blame the mother for not protecting her child, the opinion being that a responsible and caring mother would have broken off her relationship with her husband, the step-father to her children, in order to protect her child (Daily Mail, 1997; Guardian, 1997). The husband and the gun-man received comparatively little condemnation, especially once it was revealed that the murdered child's baby brother had been born heroin-dependent, thus confirming the mother's status as irresponsible and uncaring, and thus, implicitly, an 'evil mother' (Express on Saturday, 1997; Sun, 1997).

I have tried to capture the tension inherent in this fractured category of 'mother' by using the term 'problematic mother', derived originally from a study of six heroin-

using mothers conducted as part of a Master's dissertation (Goode, 1993). This term, rather than sealing off substance-using mothers into one of two opposed categories - 'normative mother' or 'evil mother' - allows the conceptual ambiguity and tension to remain, as indeed it does in the daily lives of substance-using mothers themselves.

Aim of the thesis

Recent research around the UK (Powis, 1995; OPCS, 1996; Department of Health, 1996; ISDD, 1996; Abraham, 1997) indicates that the number of women using drugs, including alcohol, is increasing nationally, particularly among women of childbearing age. Nevertheless it remains the case that it is still largely men who visit drug-agencies and other organisations for help (ISDD, 1996). If a woman is pregnant or has children she may be very cautious about approaching anyone for help, and may have worries about how people will judge her as a mother if they find out that she uses substances. In addition, the study of heroin-using mothers referred to above (Goode, 1993) suggested that some women respond to pregnancy by increasing their drug-use, a finding hitherto unexplored in the literature. It was these three issues together - that is, the known rise in substance-use among childbearing women; women's reluctance to approach agencies for help; and the possibility that pregnancy and early motherhood may in fact trigger an escalation of drug-use among some women - which prompted my initial interest in exploring the lives of substance-using mothers more deeply.

Thus the aim of this thesis is to investigate in detail what it means and how it feels to be a substance-using mother. By studying one example of the category of 'problematic mother', it enables an analysis of contemporary notions of

motherhood. At the same time the whole issue of women's use of substances generally is far from straightforward, and this will be addressed in Chapter Three and subsequent chapters looking at how the research respondents themselves felt about their substance-use and the functions it performed in their lives. The study uses grounded theory techniques (Glaser and Strauss, 1967; Glaser, 1978; Strauss, 1987; Strauss and Corbin, 1990) to analyse interview transcripts and data gathered from fifty-four individuals, including forty-eight women substance-users, five partners and one mother of a respondent, speaking about their everyday lives and perceptions, to enable a more detailed and textured picture to be built up of the experience of being a substance-using mother. The originality of the study lies in the comprehensive range of psychoactive substances used by the respondents, the wide diversity of the sample in terms of age, lifestyle and experiences, and the close attention paid to the everyday details of the respondents' lives, including their own experiences of childhood and their current social contexts.

Review of the literature

A review of the literature related to mothers and substance-use revealed a range of unanswered questions about the women's own perceptions of their experiences, and little on the everyday work of the joint activities of mothering and substance-using. The initial starting-point into the literature was an examination of substance-use related to pregnancy and birth (see, *inter alia*, Chadwick, 1988; Kearney and Norman-Bruce, 1990; Fraser and Cavanagh, 1991; Kearney and Ibbetson, 1991; Siney et al, 1995; Hepburn, 1996; Bunford, 1997). This comprises by far the bulk of the literature specifically on drug-using mothers. Written by obstetricians, paediatricians, midwives, nurses and social services professionals, this literature

typically emphasises the dangers of drug abuse *in utero*, the difficulties of working with this patient or client-group, and protocols to be followed during labour and birth (for example, Williams, 1983,1989; Dawe et al, 1992; Siney, 1995; Hepburn, 1996). This literature on the effects of substance-use in pregnancy generally uses a narrow medical and pharmacological focus, and where the mothers themselves appear, it is often within a framework of individualised psychopathology, so that they may be characterised as irresponsible and prone to deceit (for example, see Williams, 1983, 1989). Texts which avoid an emphasis on maternal psychiatric morbidity nevertheless retain a strong focus on physical morbidity (Siney, 1995) and there is little acknowledgement of the mother herself as a competent, rational actor (Colten, 1982; Taylor, 1993).

Following on from this literature there are now increasing numbers of publications dealing with the broader social and policy responses to pregnant and mothering drug-users (see, *inter alia*, Chavkin, 1990; McGinnis, 1990; Harrison, 1991; Merrick, 1993; Goode, 1995a). These originate mainly from the United States, where increasing interest has been sparked by rising public concern over pregnant women using crack-cocaine (for example, see Barr, 1989; Besharov, 1990; Hansen, 1992). Punitive responses, such as the ‘Minnesota crack-baby law’ of 1988 (Horowitz, 1991) which legally requires doctors to test pregnant women and new-borns for a range of illicit substances (consent is not required), and then to inform social services of any positive test results, has been linked by commentators to wider debates over foetal rights and abortion control as a method of exercising surveillance and control over women’s bodies and reproductive freedom (Drucker, 1990; Maher, 1990, 1992; Siegel, 1992; Daniels, 1994). However, in Britain, as

noted earlier, the legal response has been more muted, with the only dramatic legal battle so far over this issue being the ‘Berkshire Case’ of 1986 when a couple, both persistent heroin-users, had their baby involuntarily removed from their care (Levin, 1987; Perry, 1987). There is recent evidence, however, that this softer British approach may be changing, as media interest begins to raise awareness of drug-using parents (Daily Mail, 1997; Guardian, 1998a)

The Children Act of 1989 asserts the principle that ‘the best place for children to be brought up and cared for is within their own family’ (Department of Health, 1991:5), but the responses of the legal, social services, probation and criminal justice system generally tend to remain cautious of substance-using women as parents, despite encouragement by bodies such as the Standing Conference on Drug Abuse (SCODA, 1997) which advises that illicit drug-use alone should not be taken as an indication of poor parenting ability. There has so far been little Government interest in the issue of substance-using parents: the national five-year drug policy, Tackling Drugs Together, set out in a White Paper in 1995 by the former Conservative Government, contained only three references, in passing, to the specific needs of drug-using women, including only one mention of child care needs (Goode, 1995b). Thus, as with the medical literature, official policy at local and national level has so far shown little awareness of, or interest in, substance-using mothers other than a concern with the effects of their behaviour on foetal and child well-being.

This absence of the mother or substance-using woman herself as an active agent has been addressed in sociological and psychological studies of the lives and experiences of substance-users, mainly illicit drug-users. The historical literature

(Berridge and Edwards, 1981; Kohn, 1992) documents the ways in which substance-use has been a large part of women's daily lives in this country. Opium-use in the nineteenth century, and cocaine-use in the early decades of the twentieth century, were both seen as very much a woman's activity, cutting across class boundaries, and attracting little censure. Studies of the rise of illegal heroin-use and the daily lives of 'junkies' on the street in the 1960s and later, however, shifted the emphasis away from women and onto young men (Finestone, 1957; Sutter, 1966; Preble and Casey, 1969; Auld et al, 1986; Pearson, 1987; Gilman, 1988). Where women were included in these studies it was often only as the companions of men (for example, see Lex, 1990) although this is now beginning to change (Stewart, 1987; Gossop et al, 1994). At the same time, psychologically-based studies popularised a view of substance-use as deriving from individualised psychopathology, and also tended to stress the perceived higher psychiatric morbidity of women substance-users in comparison to men (Perry, 1987; Bury, 1988; Ettorre, 1989; Taylor, 1993).

These androcentric and pathologising discourses on female substance-use have been offset in recent years by a small number of studies foregrounding women's own experiences and perceptions (Rosenbaum, 1981a; Colten, 1982; Taylor, 1993; Lewis et al, 1995). The key findings from these studies are that women drug-users, far from being passive and psychiatrically morbid, tend to be as well able as their male counterparts to 'take care of business' (Preble and Casey, 1969) and work hard to combine the two roles of drug-user and mother. Research findings have also noted drug-using mothers' commitment to traditional notions of mothering and their emotional investment in succeeding at this role (Rosenbaum, 1979,

1981a, 1981b; Colten, 1982; Taylor, 1993; Kearney et al, 1994). These studies are complemented by the very small number of experiential texts available from women substance-users themselves or family-members of users (Jeffreys, 1983; Wolfson and Murray, 1986; Stewart, 1987; Harrison, 1997).

As well as illicit drug-users, the literature also provides insights into the lives of women using prescribed medication, alcohol, and cigarettes. For example, there has been a certain amount of sociological interest in the phenomenon of women taking prescribed tranquillisers, generally benzodiazepines such as Valium, and these studies illuminate the functions that such substances may play in people's lives, for example by reducing role strain (Cooperstock and Lennard, 1979) and facilitating interpersonal relationships (Helman, 1981). In a similar way, Graham (1987a, 1987b, 1989, 1993a) has documented the functions that cigarettes can be seen as performing in the lives of women, often White working-class mothers bringing up young children in difficult socioeconomic circumstances. Such women are likely to view cigarettes as a pleasure, treat or reward - often the only pleasure they are able to give themselves. Cigarettes may also offer a temporary break or breathing-space, a mood-management strategy, or a way of saving money by cutting down on food consumption (Graham, 1993a). Again, these studies, like those on women using illicit drugs, portray women as competent actors, making rational decisions within tightly-circumscribed options, and combining as successfully as they can the two activities of substance-using and domestic caring. An awareness of the salience of the mothering role in the lives of substance-using women, and also in the data from research respondents in the current study, led back, in the literature search, to a renewed focus on this central concept of

motherhood itself, and in particular the ways in which it has been explored by feminist theorists and sociologists (see, for example, Oakley, 1979; Rich, 1977; Badinter, 1981; Boulton, 1983; Glenn et al, 1994; Ribbens, 1994). Not only motherhood, but also the concept of childhood, came under scrutiny, and in this regard the work of Chris Jenks (1982, 1996) contributed significantly to the developing analysis of the data by raising the issue of the contemporary meaning of childhood and the social value of children. Jenks also contributed the concept of social categories, such as 'childhood', being 'fractured' by 'deviant' acts. His analysis of the Bulger murder, in which he sees the child murderers being characterised as 'evil' in order to preserve intact the normative category of 'child', informed the development of the concept of the 'problematic mother' in this study. The focus on childhood and childrearing led back also to the social work literature originally explored in terms of pregnancy and birth. This literature raises questions about the meanings of parenthood and the inter-linkages between individual families and the wider society in such areas as juvenile delinquency, the cycle of deprivation, the underclass, child protection, and shifting policies on fostering and adoption (Parton, 1985, 1991; Dallos and McLaughlin, 1993; Masson, 1995). These issues are explored in more depth in Chapter Four and subsequent chapters. In addition to these broad issues of the meanings of motherhood and childhood in contemporary society, which affect any parent, substance-using mothers are affected by attitudes and policies specific to the field of substance-use. Contemporary practitioner literature, from the social work and substance-abuse field, appears increasingly sensitive to the needs of women users and there has been much written and debated on the relative merits of women-friendly or women-only

services (see, for example, Glover Reed, 1987; Women's National Commission, 1988; Thom and Edmondson, 1989; Roth, 1991; Chavkin et al, 1993; Copeland et al, 1993; DAWN, 1994; Finkelstein, 1994; Powis, 1995). In particular, there is slowly-increasing awareness of the needs of lesbian (Israelstam, 1986; Underhill and Osterman, 1991) and Black (DAWN 1989) women, and the needs of women for single-sex rehabilitation centres (Cuskey and Wathey, 1982; Bevan and Morris, 1995), although all these clearly remain live issues for discussion, and practice on the ground continues to remain largely androcentric in philosophy and approach (Troupp, 1990; Moore, 1996).

The most significant recent development for women substance-users is perhaps the professional 'discovery' of 'dual diagnosis', which is to say the diagnosis in increasing numbers of substance-users of a history of sexual abuse, and the concurrent awareness in the sexual abuse treatment field of the problematic use by their clients of psychoactive substances (Young, 1990; Lex, 1991; Della-Tolla, 1992; Simpson et al, 1994). However, as with the whole issue of women-sensitive services, while much is debated in the literature and at conferences, little appears to actually change in day-to-day practice.

These broad bodies of literature can thus be seen as feeding into the overall understanding of the contemporary phenomenon of substance-using mothers. They help to inform the analysis of the data, and the discussion of the findings, throughout the thesis. In addition, these bodies of literature needed to be reviewed in the light of sociological and anthropological literature in order to provide a clearer theoretical framework for the analysis. Role theory (Becker, 1963a; Callero, 1985; Serpe, 1987) was clearly of key importance in originally designing

the research, when the focus was strongly on how women combined the contrasting roles of addict and mother. Thus, during the initial Master's research, the key influences were longstanding research on the sociology of deviance and role theory. Role theory suggests that a role is a set of behavioural expectations associated with a status, while a status is a particular position in society. Becker (1963a) developed the concept of primary or 'master' status and subordinate statuses derived from Everett C. Hughes' work (1945), suggesting that one example of a 'master status' could be that of 'deviant' and that treating someone 'as though he [sic] were generally rather than specifically deviant produces a self-fulfilling prophecy ... [for example] The drug addict finds himself forced into other illegitimate kinds of activity, such as robbery and theft, by the refusal of respectable employers to have him around' (Becker, 1963a:34). This focus on a 'master status' led to the concept of competing or disjunctive master statuses, and a view of the heroin-using mothers in the Master's study as 'reluctant non-conformists', who negotiated with maternity staff to have their status of 'mother' given primacy, while staff instead emphasised their deviant and stigmatised status as 'junkie'. Thus, Goffman's (1969, 1972) exploration of facework and impression management later proved very useful in conceptualising how respondents managed interactions with others. Work by other sociologists on the construction of folk devils and moral panics (Becker, 1963b; Cohen, 1972; Hall et al, 1978; Ben-Yehuda, 1986), deviance and stigma (Garfinkel, 1956; Erikson, 1962; Becker, 1963a, 1963b, 1964; Davis, 1963; Scambler, 1984; Scambler and Hopkins, 1986), as well as theories on contamination, danger and risk by Douglas (1966, 1992) gave further important insights into how professionals and others sometimes

responded as they did to mothers in the study: in particular, Douglas' (1992) work enriched the research by her contribution, from an anthropological perspective, on what appears to be a deep human need to maintain intact categories and the consequent shock resulting from fractured categories.

In order actually to conduct a competent study on substance-using mothers, however, much had to be learnt about the design and process of research itself. A range of literature was drawn on, illuminating the challenges of researching drug-users (Rosenbaum, 1981a; Kaplan et al, 1987; Taylor, 1993; Inciardi et al, 1993; Fitzgerald and Hamilton, 1996), and conducting research on sensitive topics (Renzetti and Lee, 1993), particularly emotionally painful areas (Rothman, 1986; Cannon, 1989; Tait, 1990). The epistemological literature included the work of Cook and Fonow (1984), Acker et al (1983), Harding (1991), and Williams (1993), which provided an introduction to the problematic and socially-produced nature of knowledge. This investigation into epistemology benefited from a feminist critique of patriarchal modes of knowledge production, particularly the thorny issue of the process of research, and the relationship between the researcher and the researched.

Thus this thesis drew on eight broad fields of literature, which may be summed up as firstly the medical and social services concern with the foetal and postnatal health of substance-exposed infants; secondly, state and local authority responses to women using substances while pregnant or rearing children; thirdly, historical, psychological, sociological and experiential literature on the daily lives of women using illicit substances; fourthly, literature documenting and theorising women's use of licit substances such as alcohol, benzodiazepines and cigarettes; fifthly, the

body of literature on the concepts of motherhood and childhood, and the state's interaction with the family; sixthly, practitioner literature from the substance-use field, including the issue of childhood sexual abuse and its relationship to subsequent substance-use; seventh, sociological and anthropological literature on concepts related to deviance, stigma, and pollution; and finally literature on the conduct of the research project itself, exploring issues of epistemology and methodology.

Unanswered questions

Despite this large body of literature which was reviewed during the course of the research, four main questions remained unanswered about the everyday lives of substance-using mothers, and it is these which the current study addresses. These four problematic areas of interest are explored throughout the thesis, but will be presented here in brief.

1) Substance-using mothers' own experiences of being mothered as children

The first area of interest concerns the mothers' backgrounds and the experiences which they have had which they see as affecting their own parenting practices. For example, as noted above, there is now beginning to be increasing professional interest in the issue of 'dual diagnosis' and the linkages between childhood sexual abuse and later substance dependence. However, we still know little about other areas of childhood which substance users themselves may feel have an important bearing on their later lives. It would seem that, in order to better understand women's experiences, we need not simply to concentrate on isolated issues such as childhood sexual abuse, but get a broader sense of the whole context of the

mothers' own upbringing, including an analysis of the context and impact of patriarchy in their lives. This understanding of the mothers' backgrounds would seem to be of clear importance in developing more sensitive therapeutic interventions. In addition, by raising awareness of the struggles and burdens many have had to contend with, it is hoped that a shift in public perception can be effected, reducing the level of blame and hostility many substance-using mothers endure as inhabitants of the category of 'evil mother', and replacing this hostility with an informed and empathic acknowledgement of the context within which women may begin their substance-use.

2) The everyday contexts within which substance-using mothers live

The second area concerns an understanding of the everyday texture of the mothers' daily lives, an understanding which again is very limited from research so far conducted. The conceptual framework of 'problematic motherhood' can help in teasing out issues of wider substantive interest from the details of individual respondents' lives: issues of taking and losing control over their own lives and their children's lives, struggling for autonomy in the face of macro and micro-level barriers which threaten to defeat their attempts to build a 'normal' family life free from outside interference and disruption. By understanding some of the pressures on substance-using mothers which act as centripetal forces continually threatening to explode their family lives, a clearer picture can emerge of the work done by mothers generally to continually constitute and reconstitute a cohesive family life and to act as mediators between their families and the wider social network.

3) The relationships between substance-using mothers and their children

This thesis seeks to answer questions about the impact of their children on mothers' lives, from the birth of their first child up to grandmotherhood, and the ways in which such an impact may be differently experienced according to the child's gender. Alongside this is a greater need to understand the impact of the mother's substance-use on the relationships between herself and her children, and for example her fears concerning her own children's substance-use in the future. The whole area is one of increasing concern among policy-makers, and at the same time contributes to a greater understanding of the meanings of contemporary motherhood generally, and in particular enables a closer analysis of the dimensions of what is understood by 'good mothering'. For example, a key problematic for many mothers would seem to be that they are being held responsible for their children's well-being without having access to the material or interpersonal power that would enable them to exercise that responsibility effectively. One major dimension of their perceived responsibility is related to the issue of protection of their children, especially from potential male predators. Thus a feminist analysis of motherhood allows questions of protection, power and responsibility to be explored in relation to normative constructions of 'good motherhood' and its counterpart, 'evil motherhood'. In this way an analysis of the everyday lives of substance-using mothers may not only offer pragmatic benefits for those professionals supporting substance-using mothers in their parenting role, but would also contribute to theorising contemporary motherhood generally.

4) Functions of psychoactive substances in mothers' lives

The fourth area of interest concerns the part psychoactive substances may play in the mothers' own lives. Researchers such as Rosenbaum (1981a) and Taylor (1993) have demonstrated that women drug-users are competent actors who make rational choices over their substance-use, based on a cost-benefit analysis: for example, they may choose to switch from smoking to injecting heroin in order to use expensive resources more efficiently, or earn money for their drugs by street prostitution rather than shoplifting if the criminal justice consequences are less (Taylor, 1993). Graham (1989, 1993a) has demonstrated similar choices among cigarette-smokers, for example choosing to smoke in order not to eat, and both she and researchers studying tranquilliser-use (Cooperstock and Lennard, 1979; Helman, 1981; Prather, 1990; Ettorre and Riska, 1995) have developed theoretical schema for understanding the many different functions such substances may perform; that is, as a mood-modifying strategy, as a reward and so on. It seems appropriate now to begin to tie together these theoretical findings from these disparate fields of substance-use, and, in this study, to attempt to build a more coherent theoretical framework which can account for the various ways in which substance-using mothers may, conceptually, structure substance-use into their lives, possibly enabling them to function more effectively, in their view, as 'good mothers'.

These, then, are the four basic questions which have been identified both from the research data as being significant issues in the respondents' lives, and from the literature as leaving many questions still to be answered. Answers to these questions, it is hoped, can help to provide a fuller and more coherent account of

many aspects of the everyday lives of substance-using mothers. This will contribute pragmatically to more appropriate and effective therapeutic interventions, and thus the relief of often intense distress for these women and their families. At the same time, understanding these women's lives in more depth will also allow the generation of theory about aspects of their experiences of relevance to others: to other substance-users, to other mothers, and to other 'deviant', stigmatised or disempowered groups.

The next chapter, Chapter Two, will examine in depth the conduct of the research, looking at issues of epistemology and methodology, how the research was actually achieved, and some of the ethical and other dilemmas that were confronted along the way. Chapter Three introduces a historical dimension to the understanding of substance-use and the varying social responses to it. It sets out some of the theoretical challenges that women's substance-use poses and details ways in which feminists and others have attempted to overcome these challenges. Chapter Four then completes the introductory background to the project by offering an exploration of the social construction of motherhood and childhood, the relationship of the family to the state, and social responses to substance-using mothers. Chapters Five to Nine then provide a grounded-theory analysis of data drawn from interviews with fifty-four respondents, looking in turn at the respondents' backgrounds and the contexts in which they mother, their relationships with their children and their experiences of mothering, and the functions which substance-use appear to perform in their lives. Chapter Ten then draws together the key findings from the research, and discusses these in terms of empirical and theoretical developments arising from the thesis.



Chapter Two

Researching A Hard-To-Access And Vulnerable Population: Some Considerations On Researching Substance-Using Mothers

Introduction

In this chapter the discussion of the design and conduct of the research will comprise five parts. First the feminist epistemology underlying the project will be examined, looking at the importance of enabling women to speak about their experiences, particularly those which usually pass unnoticed or unremarked, and the need to allow room for these ‘hidden accounts’ to emerge, and also briefly reviewing the interconnections between patriarchy and women’s substance-use and mothering experiences. Secondly the research methodology will be reviewed, including the criteria for drawing the sample and a discussion of the research instruments developed for gathering the data. The third section of this chapter will then discuss the research process, as it evolved over more than two years. This section will look at the issues of recruitment of the research sample, and the conduct of the interviews. There were also many personal, ethical and political issues raised by this research which needed to be dealt with, and these issues are discussed in the fourth section of this chapter, which looks at the question of rapport, vulnerability and the boundaries of the research-relationship. The final section discusses the data analysis.

The epistemology of the project: researching 'hidden accounts'

The study is informed by a theoretical perspective developed from the work of writers including Rich (1977), Oakley (1981a), Smith (1988, 1990, 1993) and Jeffreys (1990). Their work, which is broadly viewed as coming under the rubric of radical feminism, presents an analysis of society suggesting that the fundamental root of all oppressive conditions lies not in economic, 'race' or class structures but in the institutionalised inequity of power in female and male relations (Bell and Klein, 1996). This general analysis of society may be termed patriarchy, compulsory heterosexuality, 'the battle of the sexes', sexual politics or similar terms conveying an understanding of gender-based power structures (see, for example, Davis et al, 1991). Gendered power inequity expresses itself not only in gross forms, for example gender-based occupational segregation (Walby, 1988), but in subtle and diffuse forms, as wide-ranging as differential food consumption (Delphy, 1984; Brannen and Wilson, 1987), and even the structuring of language and the differential credibility accorded to speakers (Daly, 1979, 1984; Spender, 1980; Smith, 1993). This understanding of patriarchy has been used to contextualise the respondents' experiences and perceptions, from their experience of extreme physical violence ignored by police, to their inability to be taken seriously when they expressed diffuse fears or pain. The study drew on feminist understandings of women's experience of motherhood (for example, Oakley, 1974a, 1974b, 1979; Rich, 1977; O'Brien, 1981; Boulton, 1983; Gordon, 1990; Glenn et al, 1994; Ribbens, 1994) and substance use (for example, Perry, 1979; Gomberg, 1982; Ettorre, 1989, 1992, 1995, 1997; Oppenheimer, 1989, 1991; Graham, 1993a).

‘Thinking from the perspective of women's lives makes strange what had appeared familiar, which is the beginning of any scientific inquiry’ writes Sandra Harding (1991:150) and this assertion is a good place to start when exploring the epistemology of researching women. Starting from the standpoint of women, and enabling women to speak about their daily lives can be powerful. As Gordon (1990:127, italics in original) says, feminism is ‘concerned with *finding a voice*, giving representation to women and working against cultural exclusion’, thus enabling what Oakley (1981a:48-9) characterised as an ‘articulated and recorded commentary by women on the very personal business of being female in a patriarchal capitalist society’. Graham (1984a:119) similarly avers that ‘women telling stories in a patriarchal society ... has a methodological significance beyond medical sociology’ and a central aim of this study is without doubt the commitment to giving a voice to women, especially those who are seldom heard and who lack the resources to make themselves heard. Achieving this aim has proved an enduring struggle in many academic disciplines, including sociology. Work from the school of ‘underdog sociology’ (Gouldner, 1968), which sought to open up discursive spaces in the dominant sociological paradigm to allow those on ‘the other side’ (Becker, 1964) to speak, although consciously taking sides with the powerless (Becker, 1967), has nevertheless been generally unable to position itself outside prevailing exclusive ideologies. Even though, as Becker (1967:244) remarks, ‘it is no secret that most sociologists are politically liberal’, sociology has continued to struggle to open discursive spaces in which may be heard the voice of ‘the Other’, ‘the insider’ or ‘the feminine’ (Hartsock, 1983; Haraway, 1988; Smith, 1990; Harding, 1991). The normative social actor remains, in sociology as

elsewhere, 'masculine', and the accounting of those everyday experiences making up the fabric of social life remains also 'masculine'. This then leaves the 'feminine' occluded, with no ready language with which to speak her own, specifically 'feminine', experiences, so that, when she attempts to speak, the dominant masculine discourse is interrupted.

As Smith (1993:189-190) describes the effect of interruption: 'Speaking from experience has the power to disrupt discourse, not simply because the feminine speaks and when it speaks it disrupts, but because women speaking their experience as women, speak from where they are in their sexed bodies as they live. [In a sociology for women] sociological discourse is always exposed to being surprised and changed by having to rediscover society through the experience of those who live it'. This effort to 'surprise' the dominant discourse involves a cost for those who attempt it, and techniques of muting, ridiculing, trivialising, ignoring, denigrating, and personal attack are employed to minimise and cover over this disruption (Daly, 1979; Spender, 1980; Daly and Caputi, 1988). As Worrall (1990:9), in a study of female law-breakers, notes:

'one way of ensuring the "infinite continuity of discourse" (Foucault 1972:25) is to demarcate its boundaries by employing "practices of exclusion" (Gordon 1977:15). Such practices might include the prohibition of certain topics on grounds of "irrelevance", the disqualification of certain individuals from being authorised speakers, and the rejection of certain statements as illegitimate.'

Worrall (1990:11) goes on to quote Ardener (1978:21), who writes:

‘The theory of mutedness ... does not require that the muted be actually silent. They may speak a great deal. The important issue is whether they are able to say all that they would wish to say, where and when they wish to say it. Must they, for instance, re-encode their thoughts to make them understood in the public domain? Are they able to think in ways which they would have thought had they been responsible for generating the linguistic tools with which to shape their thoughts? If they devise their own code will they be understood?’

It is therefore a constant struggle to continually bring a discourse of women’s lived experiences to the fore, as it is as continuously subverted and submerged again within the dominant masculinist discourse. This becomes apparent when the concept of the ‘hidden account’ is used as a sensitising tool in order to resist the occlusion and denial of inarticulate aspects of experience which would otherwise pass unnoticed in research.

To understand this concept, it is necessary to think of three possible levels which social actors may use when giving accounts of themselves. (These three levels can be symbolised by the picture ‘Three Worlds’ by M. C. Escher, shown at the beginning of this chapter, in which the levels can be thought of as represented respectively by the reflections on the surface of the pond, the floating leaves, and the fish under the surface.) There is, on the mundane level, the ‘public account’ (Cornwell, 1984), which tends to present a bland, even banal, image of the self, neither stigmatised nor open to discredit (Goffman, 1968, 1969). The second level,

the 'private account' (Cornwell, 1985), is an account of the self which is shared with friends, family, and trusted colleagues. It is more vulnerable than the public account, but retains many elements of impression management in order to present a good 'face' (Goffman, 1968, 1969, 1972) to others. The third level, which I call the 'hidden account', is the account of the self which is almost without words (alexithymic), because the experiences that would be spoken are experiences largely unrecognised by the dominant masculinist discourse - and when they are spoken they are repeatedly perverted or discounted. This experience is as true for men as for women, and is an inevitable consequence of the dominant discourse of patriarchy. We may share elements of this account of the self only with a particularly intimate friend, a therapist or self-help group, or indeed with no-one. It will be the level least amenable to disclosure through research (Cornwell, 1984; Duncombe and Marsden, 1993; Ribbens, 1994), but we can expect that it will be articulated partially, in hints, pauses, silences, and dreams. 'In the interstices of language', writes Adrienne Rich (1977:249), 'lie powerful secrets of the culture'. It is thus on this third level that are found those aspects of social reality least spoken of, least amenable to research, and yet arguably most significant in shaping our societal relations and in reproducing the 'relations of ruling' (Smith, 1990) which constrain and govern each of our lives. It is on this level that patriarchy - as a set of social relations between women and men, essentially predicated on inequity - will be most likely to show its effects, effects which are largely denied conscious or spoken expression in public and private accounts. By using this model of 'hidden accounts' I seek to provide a conceptual space for discussion and analysis of issues, such as pervasive fear among women of male violence or abuse (Bevan,

1995; Painter, 1995), as *significant* but not *defining* experiences within women's lives.

For example, in the current study several respondents made reference to fears such as being afraid to live in a hostel with men, or being so afraid to sleep alone at night that they preferred to sleep elsewhere than in their own homes. This experience of fear, because it was not the explicit focus of the study, was all too likely to pass unnoticed or be discounted as irrelevant. It is an experience both indefinably diffuse and curiously everyday and taken-for-granted, with little conceptual space within which it can be located. The dominant masculine discourse occludes recognition of it, even though such subtle but pervasive experiences can have a large impact on respondents' lives, and clearly affect their actions and lifestyles.

Another example of significant experiences which often pass unrecognised and unregarded in the dominant discourse concerns not just a diffuse fear but the actual experience of sexual violence, affecting somewhere between 12 - 45% of all girls, depending on definition (Forward and Buck, 1981). For example, a MORI poll conducted for Channel 4 in 1984 found prevalence rates of sexual abuse affecting one in eight girls and one in twelve boys (Nelson, 1987). Rape and domestic violence are widespread (Mullen et al, 1988); pornography and the ubiquitous threat of sexual violence have an impact on every woman and girl in this society (Caputi, 1988; Everywoman, 1988; Driver and Droisen, 1989; Smith, 1989). And yet, curiously, such underlying aspects of women's everyday realities do not figure in research unless it is specifically and narrowly focused on these issues. The facts of widespread violence, abuse and threat specifically towards women and girls are

known (although the exact statistics may be contested), but most research on women is still conducted disregarding such facts, *as if* a basic equivalence existed between women's experiences and men's experiences.

Thus, even when women do speak and are heard - on the facts of sexual abuse, for example - this knowledge is disregarded and treated as irrelevant. In a different context, Becker (1967:241) has described how 'credibility and the right to be heard are differentially distributed through the ranks of the system'. Although he was not referring explicitly to gender, this 'hierarchy of credibility' can be viewed as an aspect of the process of 'perversion and subjugation' of which Smith (1993:189) speaks. It can be identified also in phenomena such as Freud's ascription of hysteria to women complaining of sexual abuse in childhood (Freud, 1962), and the current debate around False Memory Syndrome (for example, see Masson, 1984; Grant, 1993; Butler, 1994; Orbach, 1994).

Again, Sandra Bartky (1990) refers to the way in which the tensions and contradictions inherent in each particular culture crystallise into specific symptoms, such as eating disorders. We can then read these symptoms as coded but powerful symbols for those things that have gone awry in the culture. Similarly, Littlewood and Lipsedge (1987), from the perspective of mainstream psychiatry, have discussed how specific syndromes, such as agoraphobia, can be read as profoundly symbolic dramas in which individuals play out the central dilemmas of their society. These examples of the 'crystallisation of culture' are close to what I am exploring as women's 'hidden accounts' inasmuch as they are alexthymic, diffuse and yet very normal, everyday and unremarkable. As muted and inarticulate accounts of lived experience they can be read as individualised, pathologised 'personal

troubles' (Wright Mills, 1959) or, as Bartky (1990) and others are beginning to do, they can be deconstructed and made legitimate subjects for structural analysis and debate.

This exploratory model of the 'hidden account' can be seen as an example of a 'sensitising concept' (Blumer, 1954) which increases the researcher's awareness of the possible effects of the interactions of such experiences on women's lives. As Blumer (1954:7) notes, a sensitising concept 'gives the user a general sense of reference and guidance in approaching empirical instances. Whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look.' Suggesting 'directions along which to look' accords well with the feminist project of avoiding imposing orthodoxy on women's experiences and instead allowing narrative accounts to emerge. As Smith states (1993:184), 'the function of women's standpoint ... is to open up to diversity. It waits for women to define themselves, to speak their own experience'.

The contribution of a feminist approach to understanding substance-using mothers' experiences

The foregoing discussion has clarified the ways in which a feminist understanding has contributed to a commitment within this research to allow women to speak out about their everyday experiences; it has also highlighted the need to be alert to 'hidden accounts' in which experiences of oppression may be rendered distorted and inarticulate, liable to interpretation as individualised personal troubles rather than as amenable to analysis. In terms of research on substance-using mothers, however, a question could be posed regarding the ways in which feminist analyses can specifically contribute to an understanding firstly of women's substance-use

and secondly of mothering. These issues underpin the theoretical discussion of the research data throughout the subsequent chapters, but will be briefly reviewed here.

It is not suggested in this thesis that there is any direct cause-and-effect relationship between patriarchy or heterosexuality and substance-use, for example that women take substances as a conscious response to the pressures of gendered power relations. However, it is asserted that we cannot understand women's substance-use without a clear understanding of the social context within which such use is embedded. To try and generate an analysis without this wider contextualisation means that we miss many important elements in their experiences. For example, significant socially-contextualised elements in respondents' everyday lives include their relationships with male 'protectors', their limited occupation options, the availability of prostitution as a money-making strategy, their relationship with pimps/boyfriends, the attitude of the male-dominated police services and criminal justice systems, the focus on women as foetal carriers and mothers in a way that has no equivalent for fathers, and the use of sexually derogatory remarks, or the 'sex libel' (Douglas, 1992), as a component of the degradation ceremonies (Garfinkel, 1956) used to mark them as contaminated.

While such elements are background factors, most of which are relevant to non-substance-using women too, there are in addition five further and more central elements to the experiences of substance-using women. These elements shape women's use of and dependency on psychoactive substances in culturally-determined ways. There is, firstly, the continuing cultural pressure on women of the still-existent 'feminine mystique' (Friedan, 1963) and the 'beauty myth' (Wolf,

1990) which continues to place high demands on women to conform to normative notions of femininity. This links to the gendered experience of role strain among women (Cooperstock and Lennard, 1979), often as workers and housewives working a 'double shift', a pattern which remains far less common among men (Figs, 1994), and which often conceals heavy burdens of emotional and domestic caring (Graham, 1987b, 1989, 1993b). These two interacting pressures of conformity to femininity and gendered role strains are in turn linked to cultural notions of women as psychologically weaker than men, more acceptably dependent on others for support, and more prone to turn to the medical profession for medication to deal with distress (Ehrenreich and English, 1979; Perry, 1979; Gomberg, 1982; Oppenheimer, 1991). A fourth element, relevant to many substance-dependent women (Bollerud, 1990; Barrett and Trepper, 1991; Simon, 1998), is the experience of psychological trauma such as childhood sexual abuse or physical violence from current partners. Where men might respond to equivalent psychological traumas by becoming aggressive or drunk and externalising their negative mood-states (Littlewood and Lipsedge, 1987), culturally-sanctioned expressions of distress among women tend to increase the likelihood that they will turn to alcohol and other psychoactive substances in order to internalise their distress and use the substance as an everyday coping strategy. Finally, a fifth element increasing the likelihood of women using substances can be discerned in the increased acceptability of a 'post-feminist' and postmodern pursuit of pleasure by women, leading to a reduction in perceived stigma for women enjoying alcohol and drugs recreationally (Stewart, 1987; Ettorre, 1992, 1997; Henderson, 1993a, 1993b).

A feminist approach does not only help in explaining elements of women's use of psychoactive substances, but can also shed light on women's experiences of motherhood. Here, several factors come together. Initially, there is the woman's own personal and social experience of having been mothered and how this will subsequently affect her own mothering. Adrienne Rich, in her study of motherhood (1977) regards women reared under patriarchy as 'wildly unmothered' themselves and thus hard-pressed to offer optimal mothering to their own children, and other theorists have also noted the difficulties faced by mothers in a context where it is only women who are expected to rear children (Dinnerstein, 1977; Chodorow, 1978). Related to this issue is the weighty edifice of socially-constructed normative motherhood, linked to notions of love and self-sacrifice, and to guilt over perceived failure when, for example, non-full-time mothering is associated with 'maternal deprivation' (Bowlby, 1951, 1969, 1979). There is also the context within which the woman may become a mother. Under patriarchy, this context may include the experiences of gendered inequity in relationships; a sexual history encompassing violence, abuse and lack of consensuality; and an economic and social context where pregnancy and motherhood are likely to make women economically dependent (on their partner, their family, or the State) while paradoxically providing almost the only available source of status and pleasure (Boulton, 1983; Gordon, 1990; Kaplan, 1992; Glenn et al, 1994).

In addition, as discussed further in Chapter Four, on mothering, there is the physical and emotional work of caring which is daily involved in childrearing, housework and caring for sick or elderly relatives, which, for some women, may also be linked to a deep sense of dissatisfaction, depression and self-blame as they

find that what they had believed would fulfil them in fact bores and frustrates them (Comer, 1974; Brown and Harris, 1978; Oakley, 1979; Boulton, 1983; Holdsworth, 1988). This aspect is linked also to the wider position of women in society, where gendered power inequity places on mothers (and mothers alone, rather than on parents) the obligation to be responsible for the day-to-day well-being of their children (Kitzinger, 1978; Boulton, 1983; Graham, 1984b; Gordon, 1990) without ensuring access to the power-structures which would enable them to fulfil those responsibilities - a situation I term 'powerless responsibility'. Finally, there is often the emotional relationship with a male partner, based on socially-constructed ideologies of love and sex, within a context of 'compulsory heterosexuality' (Rich, 1984) where 'Women's maintenance of men, voluntary or forced, paid or unpaid, is what generates men's power and enables them to continue living on women's energy' (Brunet and Turcotte, 1988:46) and where sexual relationships and sexual desire, within a framework of compulsory heterosexuality, is an expression fundamentally of 'eroticised power difference' (Jeffreys, 1990:299).

Finally, underlying and supporting all these different aspects, is the continual occlusion and trivialisation of these issues. All of these issues could be said quite realistically not to be in any sense specifically 'radical feminist' or even necessarily 'feminist' at all - for example, the statistics on child sexual abuse are widely known and are seldom now contested - but it appears that it is only feminists who persist in naming these issues as problematic. Other perspectives may note the same patterns of behaviour (such as gendered sexual violence) but find them unproblematic, seeing them for example as components of normal sexual

development, based on innate biologically-based sexual difference, and as not only inevitable but as actively pleasurable or as potential sources of pleasure for women (Ellis, 1897; Freud, 1962; Comfort, 1979, 1984; Califia, 1981; Rubin, 1982; Samois Collective, 1982; Vance, 1984, Paglia, 1995). It is because of this occlusion and trivialisation that these issues continue to remain almost always at the level of 'hidden accounts', inarticulate and divisive, understood only in terms of individualised personal troubles and susceptible only to personal remedies such as self-medication to block out emotional pain and confusion.

Designing the research

Bearing the foregoing conceptual framework in mind, the discussion now turns to the design of the research, looking first at the criteria for inclusion in the sample and secondly the choice of research instruments. The population I wished to study were women who identified themselves as mothers having a current or previous problem with substance-use, and living within the West Midlands area.

The geographical area of the West Midlands was chosen because it offered both pragmatic and theoretical advantages, being local to Warwick University where the research was based, and being a large geographical area which includes both urban and rural locations, with the second-largest city in Britain and numerous inner-city and deprived areas, as well as isolated villages and affluent small towns. Both Birmingham and Coventry have thriving illegal drug economies, and drug-users in the smaller towns such as Leamington Spa and Rugby, while having their own indigenous dealers, also tend to travel to Coventry or Birmingham in order to buy their supplies.

‘Mother’ was originally defined for the purpose of the research as only including those biological mothers whose children were currently with them - that is, actively mothering. It rapidly became clear that life is messier than that. Some mothers had some of their children at home and others elsewhere; children moved in and out of their mother's care; mothers usually maintained parental responsibility even when their children were not physically with them; and all of the sample of women who had given birth to children continued to regard themselves as mothers even when their children were permanently living away. It also seemed appropriate to include in the sample women who had not themselves given birth but who were raising step-children: in the event only one respondent fell into this category.

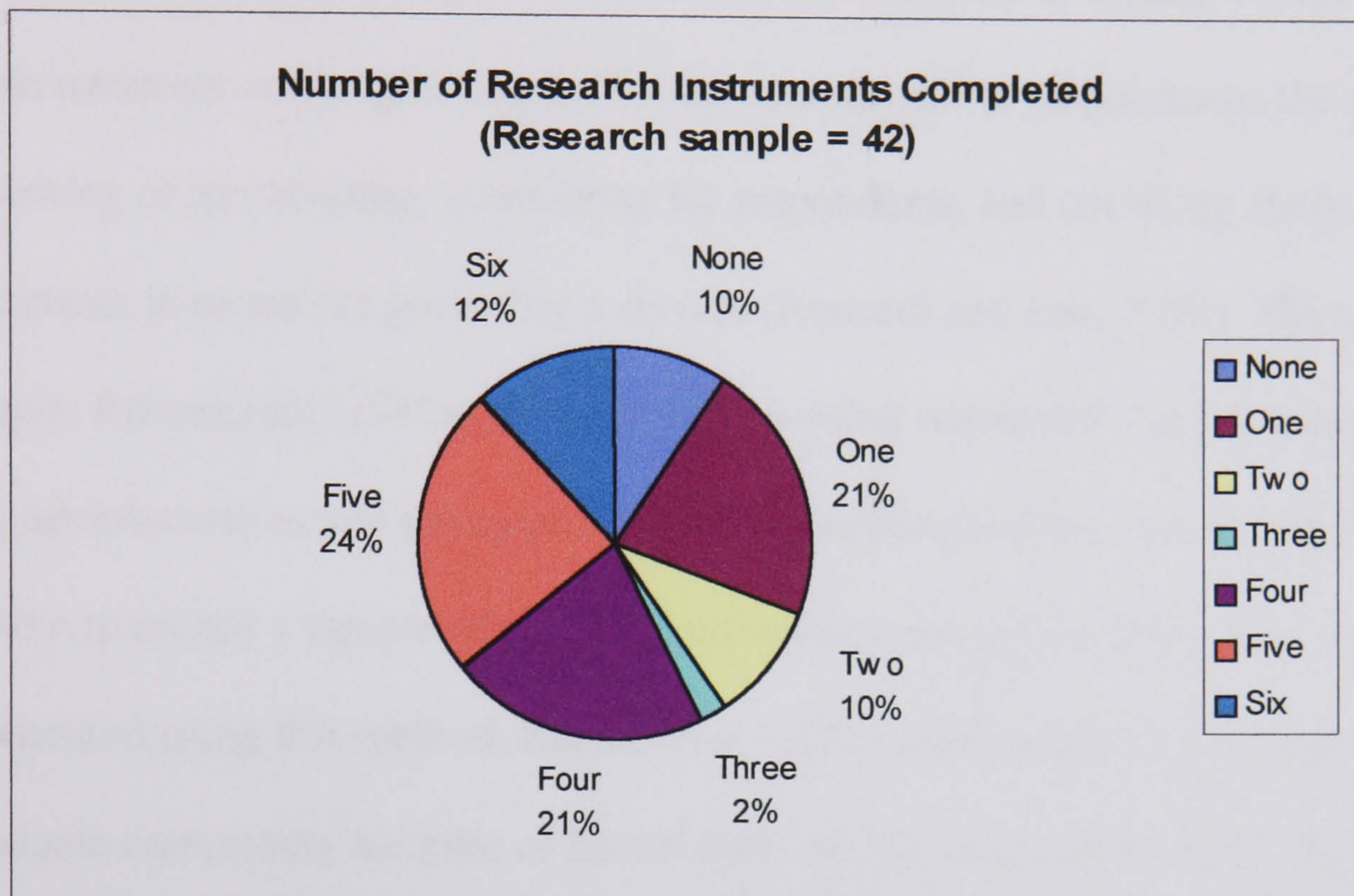
The category of ‘substance-user’ encompassed any woman who defined herself as having, or having had, a problem with psychoactive substances. These substances included illegal opiates such as heroin, and legal opioid-based medication such as methadone, Diconal, Temgesic, Palfium, DF118s and cough linctus; benzodiazepine anxiolytics and hypnotosedatives such as Valium and Temazepam; solvents and gases; amphetamines; cocaine and crack (a derivative of cocaine); and alcohol. The women also took other substances such as nicotine, caffeine, cannabis, Ecstasy, LSD (or ‘acid’), and psilocybin (or ‘magic’) mushrooms but no woman identified these substances as causing a problem for her. While the initial focus of the research was on illicit drug-use, primary alcohol-use was added as a research focus a year into the fieldwork when it became increasingly difficult theoretically to justify its exclusion. This allowed the theory to develop away from an artificial distinction between ‘illegal’ and ‘legal’ drugs and towards a more holistic understanding of psychoactive substance-use generally.

A central tenet of the project, as discussed, was to further the collective feminist project of giving voice to the previously unspoken experiences of women and in particular to allow disempowered women to articulate, as far as possible, the ‘hidden accounts’ of their lives. Thus the aim was to enable narrative accounts to be given that were guided rather than pre-structured by the interviewer (Oakley, 1981a; Graham, 1984a; Hakim, 1987; Ogier, 1989; Ackroyd and Hughes, 1992). However, basic demographic and biographical data also needed to be systematically collected, in addition to the narrative accounts, and therefore the key tool for data-collection was chosen as a tape-recorded, semi-structured interview format (Denzin, 1978; Burgess, 1982), using a three-part interview schedule covering all the main areas of research interest, supplemented by seven other data-collection tools for more specific information. These included the revised version of the Derogatis Symptom Checklist with ninety variables (Derogatis SCL-90-R) which was used as a self-completed rating scale of psychological distress, and a questionnaire on patterns of substance-use which was based theoretically on Hilary Graham’s framework for understanding cigarette-use among working-class young mothers, and was designed to examine this framework in relation to other psychoactive substances as well as cigarettes.

The remaining five research tools were designed by myself originally to collect data only on illicit drug-use. They were amended when I began interviewing primary alcohol-users later in the research process, but remained less satisfactory for getting at the everyday reality of the lives of alcohol-using mothers.

Figure 1, overleaf, shows the number of research instruments completed by each respondent. This chart does not include the six respondents from the MA sample,

who all completed only a single interview-schedule. As can be seen, over half the respondents in this research sample (57%) completed four or more research instruments.



Having defined the research-population under investigation, and assembled appropriate research-tools for data-gathering, the next aspect of the research was to actually conduct the fieldwork.

Out in the field: contacting the sample and conducting the interviews

To begin with, contacting the research sample proved even more difficult than anticipated. As Renzetti and Lee (1993:30) discuss, 'the more sensitive or threatening the topic under examination, the more difficult sampling is likely to be, because potential participants have greater need to hide their involvement.'

Substance-using mothers offer a prime example of the need to hide involvement, and thus offer a substantial challenge to any researcher attempting to locate an appropriate sample (Gurdin and Patterson, 1987).

The main strategies used by researchers (Kish, 1965; Becker, 1970; Sudman and Kalton, 1986; Sudman, Sirken and Curran, 1988) to obtain samples of 'deviant' or rare populations include the use of organisation membership-lists; multipurpose surveys; household screening procedures; the identification of locales within which sample members congregate as sites for the recruitment of respondents; the use of networking or snowballing; advertising for respondents, and obtaining study participants in return for providing a service (Renzetti and Lee, 1993). Thus, for example, Rosenbaum (1981a) recruited heroin-using women in San Francisco using advertisements and payments for interviews and asserted that, although she was able to recruit a sample of one hundred women, she could easily have recruited five hundred using this method. Kaplan et al (1987) used snowball sampling to investigate community samples of heroin users in the United States, and Taylor (1993) in Glasgow and Inciardi et al (1993) in a range of cities in the United States, studying women injectors and crack-using women respectively, relied on locales (such as drug-dealing areas and crack-houses), key informants, and networking and snowballing strategies, and successfully recruited around fifty respondents in Taylor's case, and several hundred in combined studies by Inciardi and others.

To this list could be added the additional two strategies of reliance on peers as 'privileged access interviewers', key informants, or 'insiders' to provide entree into the population (Griffiths et al, 1993), and use of more formal gate-keepers, such as outreach workers, to make initial introductions (Taylor, 1993).

In this research, the experience was that respondents were reluctant to come forward without prior introduction, and relying on advertising in known drug-

dealing areas, as Rosenbaum had done in the United States, led to no recruits. This may be due to a greater cultural reluctance among British people to telephone strangers, and both drug workers and drug-users expressed the view that potential respondents would be highly unlikely to make contact initially in this way.

To begin the research, a great deal of effort was initially put into publicising the project and negotiating access with drug-agencies. The project was first publicised through the establishment and distribution of a regular free national newsletter, Women Who Use Heroin, from January 1994 onwards. General publicity was also achieved through display stands at two national conferences on women and substance-use, and talks at relevant West Midlands forums. As well as the newsletter, one-page and two-page summaries were also made available, and posters and cards publicising the project were handed out. A letter on the project was initially sent from the (then) West Midlands Regional Health Authority to all drug agencies in the West Midlands region, and was followed up by a letter and telephone-calls by myself. The response-rate was encouraging, with thirteen out of sixteen West Midlands drug-agencies granting access, although not all the agencies which had agreed to grant access were finally used in the project.

To alert substance-using mothers to the existence of the project, cards and posters were displayed in drug-agencies, a Black and an Asian women's centre, GP surgeries, mother and baby clinics, local schools and nurseries, family centres, a launderette, chemists and shops. The research also headlined the evening news programme of a regional television network and was publicised in two local newspaper articles and local radio news bulletins. All this activity resulted in contact from only one woman, who nervously set up a meeting at a public place

but then cancelled and was too afraid to re-contact. She did not say what drugs she was using, but told me that she had never told anyone before that she had a problem with drugs, and was too scared to go for help. Another woman had heard of a pregnancy handbook I had written, and phoned requesting a copy, but was then too frightened to tell me anything about her drug problem, and did not even want me to leave the book somewhere where she could collect it. This again highlights the levels of fear and secrecy surrounding substance-use by women.

Later in the research, access was negotiated with a range of probation centres, an alcohol advisory centre, two firms of solicitors, a prescribing general practitioner, a family centre and a primary school. As the fieldwork progressed, it became increasingly obvious that the decisive factor in the success of the research was the positive attitude of a small number of committed and enthusiastic staff-members at various sites, who were able to get the project off to a good start and who introduced the majority of respondents.

Although the research was centred in one geographical area, it was curious that the main Community Drug Team in that area were unable to introduce any clients at all to the research project, during the two years of fieldwork. It appeared that they usually had only around eight or nine mothers at any one time (out of a client caseload of around one hundred drug-users), and all their clients were judged by the staff as being too 'emotionally vulnerable' to be interviewed by me. In fact, a high proportion of their women clients *were* eventually interviewed by me, but via other contacts.

Thus, during this study, five main strategies to recruit respondents were employed with varying success, which were: the identification of specific locations (such as

drug agencies and a specialist GP); relying on gate-keepers to make introductions; asking respondents to recruit others to the study; advertising using cards, posters, newspaper articles and items on local radio and regional television; offering £5 telephone cards or stamps in thanks for participation; and asking key informants for introductions to events and places. The most successful strategies turned out to be using the waiting-room of a specialist GP as a recruiting-ground, relying on enthusiastic and helpful substance-workers and probation-officers to make introductions, and offering remuneration to encourage volunteers.

The strategy of snowball sampling was a dismal failure. Although this technique of snowballing out into the community has been found effective in previous research in drug-using communities (Kaplan et al, 1987; Taylor, 1993), almost all attempts on my part to recruit participants in this way did not meet with success. This was because women reported that they were either very socially isolated and knew no other women drug-users, or because all of the peer-group of drug-users known to them were in contact with the same drug-agency, and thus could not constitute a community sample. This is in itself an interesting finding, but disappointing from a recruitment point of view.

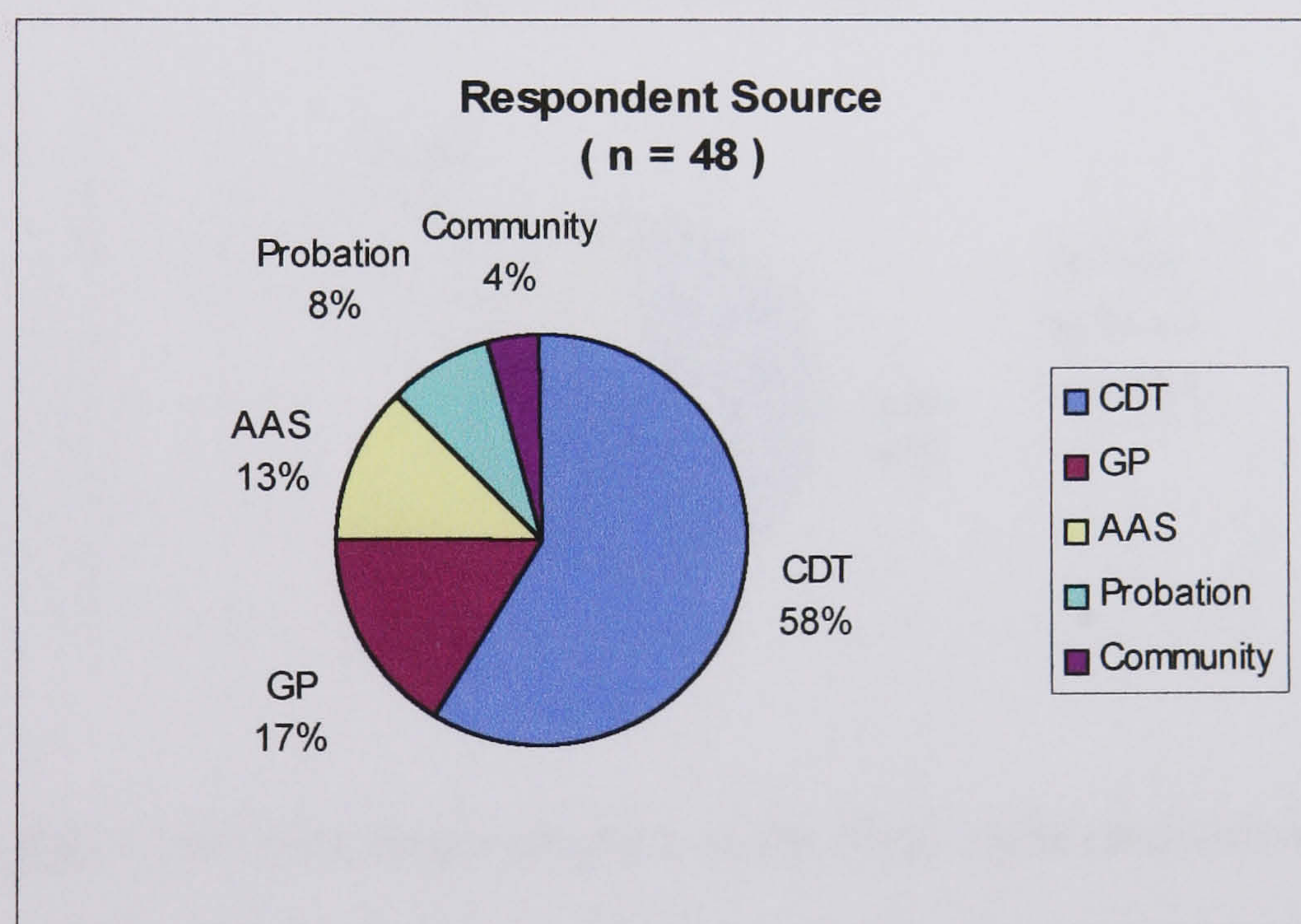
The difficulty of recruiting a community sample meant that any idea of comparison between two groups (that is, those currently in contact with agencies and those not) had to be abandoned. In the event, of forty-eight respondents, only two women constituted the 'community sample'. It was thus unrealistic to hope to recruit particular subsets, due to the extreme difficulty of recruitment generally.

When recruiting from agencies, I encouraged staff to approach women from minority ethnic backgrounds, and older women, but overall the sample was very

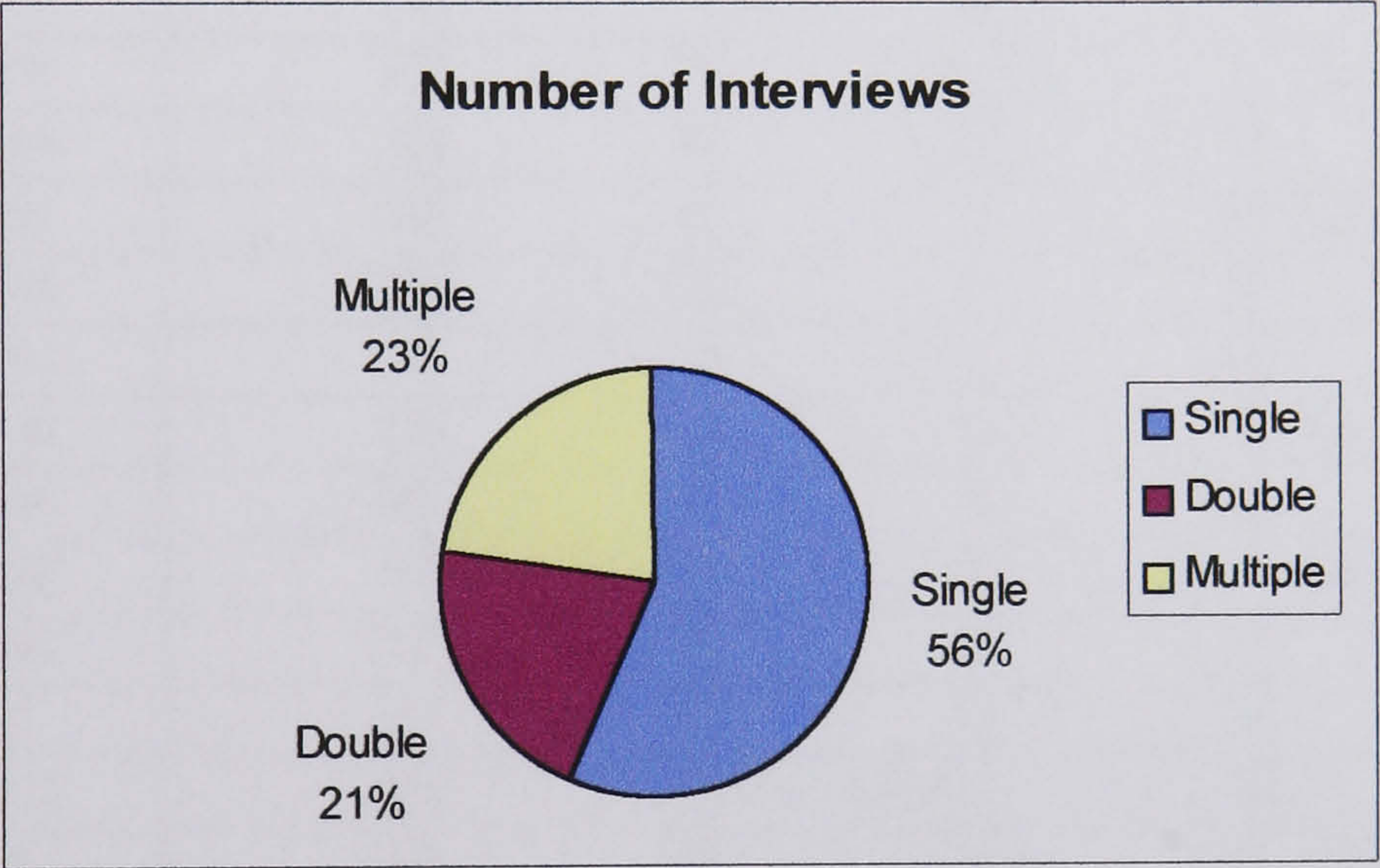
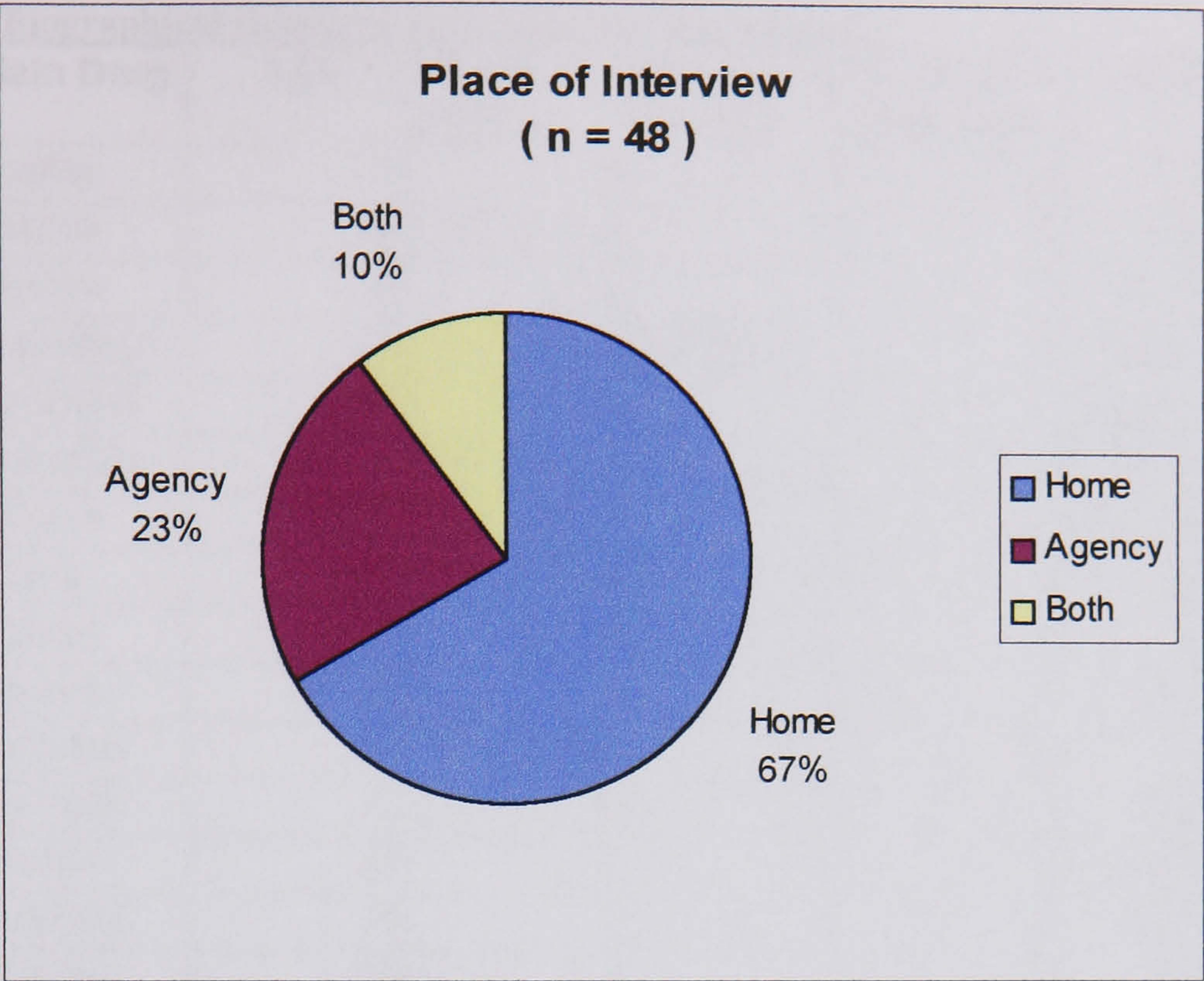
much opportunistic. Of the final sample of forty-eight women substance-users, only four were not of White European descent, being African-Caribbean, Asian, or of dual heritage.

Altogether, a total of eighty interview transcripts were obtained, giving accounts from forty-eight substance-using women and six partners or relatives.

Figures 2, 3 and 4, respectively, show where each respondent was recruited, the place of each interview, and the number of interviews conducted with each respondent.



Note: CDT = Community Drug Team; GP = specialist general practitioner surgery; AAS = Alcohol Advisory Service



Overleaf, Table 1 provides details on each of the forty-eight respondents, showing their research pseudonym; their main substance of use; their age; whether a grandmother and if so to how many grandchildren; their own number of children and whether any of those children live away from home; their relationship status and whether their partner, if any, was also a substance-user. Where their relationship status changed over the course of interviewing, this is also shown.

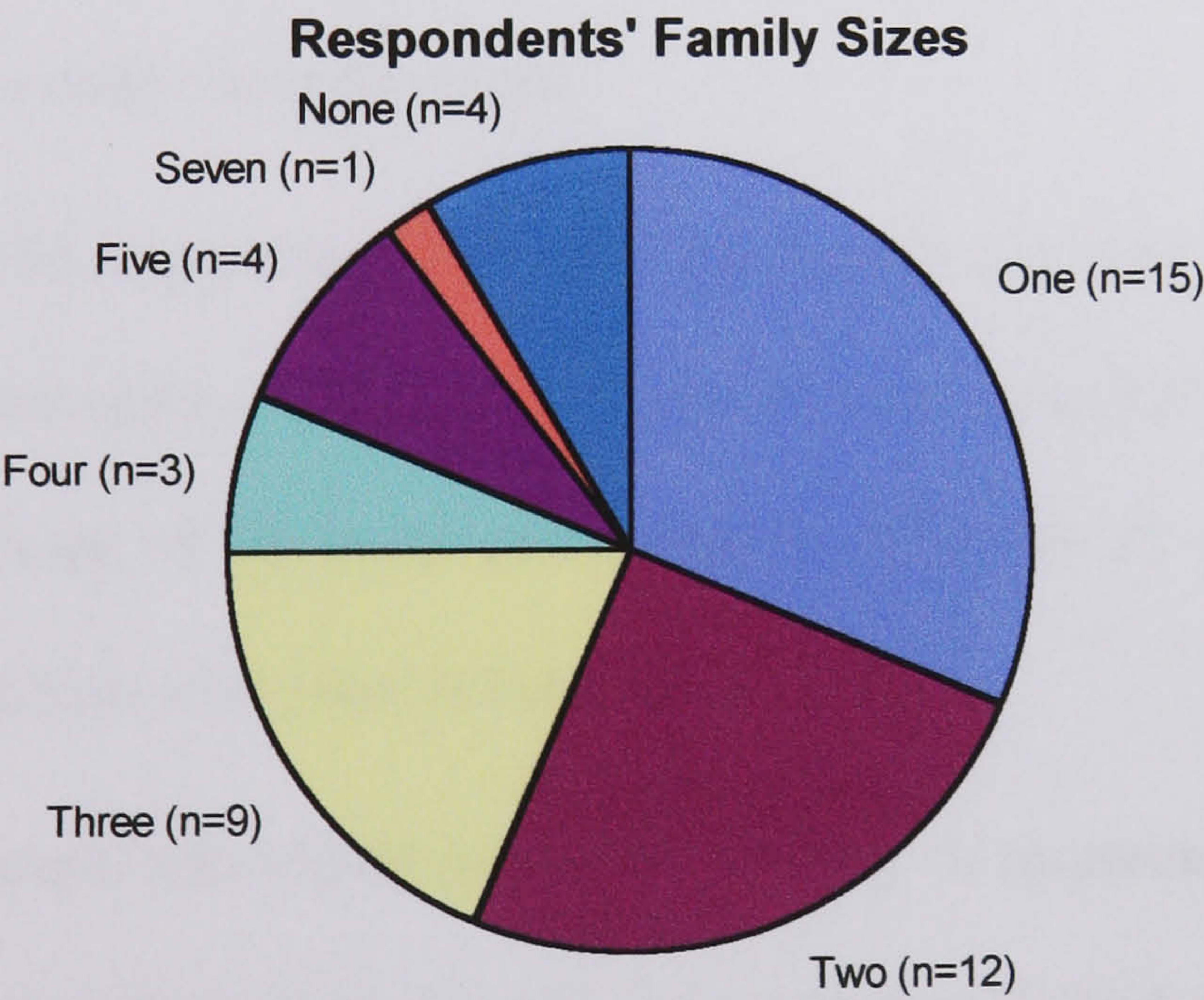
Table 1: Brief Biographical Details on each Research Respondent

Pseudonym	Main Drug	Age	Grand-mother	Number of Children	Children elsewhere	Status	Partner Using
Adele	opiates	32	0	2	1	Partner	
Alison	opiates	34	Yes, of one	5	0	Partner	
Amanda	alcohol	30	0	3	3	Boyfriend	
Angela	speed/gas	26	0	pregnant	0	Single, gay	
Anita	op/speed	30	0	2	2	Partners x3	Op/speed
Annie	op/speed	36	Yes, of one	3	1	P, then S	Opiates
Barbara	alcohol	59	Yes, of two	2	0	Divorced, S	
Bernadette	speed	54	Yes, of three	3	2	Single	
Bernice	opiates	24	0	1	0	Single	
Beth	opiates	39	0	5	0	Partner	Opiates
Beverley	sp/crack	34	Yes, of two	1	1	Single	
Carrie	op/crack	27	0	4	0	Partner	Op/crack
Cathy	alcohol	27	0	2	2	Boyfriend	Alcohol
Chris	op/crack	25	0	1	0	P, then S	
Clare	op/pills	29	0	3	3	Partner	
Deborah	opiates	22	0	1	1	S, then B	
Diane	opiates	23	0	2	1	Single	
Dilys	alcohol	57	0	1	0	Divorce, S	
Donna	opiates	30	0	3	0	Partner	Opiates
Elaine	op/pills	32	0	1	0	Single, gay	
Fiona	opiates	33	0	4	1	Partner	Opiates
Gayle	opiates	25	0	1	0	Single	
Geraldine	alcohol	34	0	5	1	Separated	
Gloria	opiates	33	0	3	2	Partner	Opiates
Hayley	alcohol	43	0	2	0	Boyfriend	
Heather	opiates	27	0	1	1	Partner	Opiates
Hilary	speed	21	0	1	0	Single	
Jackie	opiates	20	0	not mother	0	Single	
Jane	speed	41	0	2	0	Divorce, S	
Jaz	opiates	23	0	1	1	Boyfriend	Opiates
Josie	alcohol	56	0	2	0	Partner	
Joyce	op/speed	54	Yes, of two	4	2	Divorce, S	
Lisa	cod/alcohol	35	0	2	1	Partner	
Mandy	sp/Ecstasy	27	0	1	0	Partner	Sp/Ecstasy
Margaret	op/pills	35	0	1	1	Boyfriend	Alcohol
Marlene	op/alcohol	39	0	2	1	S, then B	
Maureen	speed	22	0	deceased	1	Single	
Maxine	sp/pills	39	0	1 (step)	0	Partner	
Meg	alcohol	38	Yes, of one	7	7	Single	
Nell	opiates	30	0	3	0	Partner	Opiates
Patricia	opiates	28	0	5	0	Partner	Opiates
Patty	op/speed	23	0	1	0	Partner	Op/speed
Penny	speed	28	0	2	0	Single	
Pippa	opiates	24	0	miscarriage	0	Partner	Opiates
Sally	pills	23	0	2	0	Single	
Sandra	alcohol	50	0	3	0	Partner	
Stella	opiates	31	0	3	2	Partner	Opiates
Susie	op/gas	28	0	1	0	Partner	

(Note: alc = alcohol, cod = codeine linctus, crack = crack-cocaine, gas = inhaled butane, op = opiates, pills = prescription tranquillisers and sleeping-tablets, sp or speed = powdered amphetamine. P = partner, B = boyfriend, S = single).

Numbers of dependent children living away from home long-term (currently or previously) are shown. From Table 1, it can be seen that the respondents ranged in age from 20 to 59, with a mean age of 33, and seven of the respondents were grandmothers. Numbers of children ranged between none (for four of the women) and seven, with a mean of 2.4 children, and a mode of one child per respondent.

Figure 5 shows the family-sizes for the women in the sample.



Of the total 105 children mothered by the women in this sample, 38 of the children (36%) had lived away from their mothers at any time. This situation had been experienced by twenty-two (49%) of the forty-five women who had mothered children. (The forty-five women include one step-mother, but not the three women who had not yet had liveborn babies).

Regarding substance-use, seventeen women used only opiates, nine women used only alcohol, and five women used only amphetamine, with one further woman using only 'pills'. All the remaining sixteen respondents were classified as having two primary substances of dependency, of whom twelve used opiates and another substance, while four used amphetamine and another substance.

In terms of relationship status, 20 women had a stable live-in partner or husband; 17 women were single, including five divorced women; five had boyfriends who did not live with them; five moved in or out of relationships during the course of the interview-series, and one woman was currently separated from her husband.

Two of the women defined themselves as gay, of whom one had become pregnant as a result of rape and one apparently through her work as a prostitute: both these women were currently single.

Of the 31 respondents who were involved in a relationship at some point during the interview-series, 16 (52%) had partners who were known to also be using substances, of whom the great majority, 13 of the 16, used opiates, (three in conjunction with other substances).

The sample was biased in that the majority of respondents came via drug-agencies and thus cannot be considered representative of drug-using mothers generally. In addition, with both drug-agencies and probation services, staff operated as strict gate-keepers, only approaching those women whom they deemed to be appropriate for my study (often on the basis that they thought I would find them 'interesting') and also whom they professionally evaluated as sufficiently emotionally able to undergo the interview. In the case of the alcohol service, the GP surgery and of course the 'community sample', the women were informed of the research and

voluntary participation was invited by the researcher, with the endorsement of staff where appropriate. With these sixteen respondents, therefore, they were not pre-selected (or ruled out) on the basis of supposed emotional competence, and thus eluded 'judgement sampling' by non-research staff.

In addition to the forty-eight women interviewed, another four expressed interest but did not follow this up. For those women who did decide to go ahead with the interview, almost all interviews took place in the respondents' own homes, contributing to a relaxed atmosphere, with only fourteen single or initial interviews taking place on agency premises. The majority of respondents appeared to find being interviewed a comfortable rather than daunting experience. They visibly relaxed after a couple of minutes and conversation usually flowed with little prompting from myself. In fact I was often surprised at the rapidity at which intimate details of the women's lives were disclosed. Several women also explicitly commented that they valued the opportunity to talk and be heard (cf. Finch, 1984; Kennedy Bergen, 1993), saying for example 'it's lovely talking to you, Sarah, it really is, it's so therapeutic -- I can look at my drug problem logically when I talk to you, and I never get the opportunity any other time' (Annie, 003d:13)¹. It is of course important to bear in mind that, with this as with any similar sample, the women selected themselves into the research process and only those women who were comfortable being interviewed were in fact interviewed.

For those interviews conducted in the respondents' homes, the conduct of the interview was often woven into the daily life of the household, with telephones

¹ All names of respondents are pseudonyms. The reference given refers to respondent number, interview number for that respondent and page of interview-transcript. All omissions in the text are indicated by two hyphens.

ringing, visitors calling, children talking, meals being prepared and eaten, and so on, as the interview continued over a period of perhaps several hours. For those respondents involved in drug-dealing, constant interruptions occurred from visitors keen to buy or sell drugs and, with one respondent, the interview was put on hold when a client arrived for sexual servicing.

Ethical dilemmas were posed when respondents and their partners discussed their criminal activities with me and showed off items they had recently shoplifted. I was also told of crimes where the respondents were the victims rather than the perpetrators, and where the police had failed to intervene. While this is clearly a wider issue which affects more than the drugs field alone, drug researchers in Australia (Fitzgerald and Hamilton, 1996) have found that a researcher is technically liable as accessory to the crime if s/he knows of a criminal act and does not report it, and from this concluded that it is impossible to conduct research on illicit activities if ethical guidelines are followed strictly. In this study it seemed to me more important to address the macro-level issues of domestic violence and power inequity than to break confidentiality by reporting instances of theft or fraud.

Another issue that arose during the fieldwork was that some respondents used alcohol, heroin, cannabis or crack during the actual conduct of the interview, and the majority of respondents had already taken some form of psychoactive substance earlier in the day prior to being interviewed (as part of their usual routine and also occasionally to give them 'Dutch courage' for the interview). Apart from the criminal aspects already noted, it seems that the effects of psychoactive substances on the quality of data from respondents is an interesting methodological

issue which has not previously been addressed. Only three respondents showed slurred speech and loss of concentration during interviews, which appeared to result from alcohol or tranquilliser-use rather than illegal drugs. For the majority of the respondents, however, the presence of psychoactive substances in their bodies was physiologically normal and did not noticeably impair cognitive functioning.

Overall, this research appears to differ from previous studies on substance-using women in three ways. One is the fact that dependency on all common psychoactive substances was represented, rather than a narrow focus on one type of illegal drug as is more usual (for example, see Rosenbaum, 1981a; Colten, 1982; Taylor, 1993; Inciardi et al, 1993). The second is that a very heterogeneous group were interviewed, ranging in age from 20 to 59 years, and including seven grandmothers as well as young mothers with their first babies, and representing an enormous range of life-styles and experiences. Thirdly, the study appears to be unusual among studies of substance-users, in that a great deal of attention has been paid to the wider context of the women's lives, including looking in detail at childhood and teenage experiences, relationships with family, partners and friends, work, housing, crime and criminal justice experiences, and the general social milieu in which the women live, as well as their substance-using, reproductive and mothering experiences.

An issue that ran throughout the research process was the question of my own position vis à vis both respondents and gate-keepers. As well as the ethical dilemmas encountered, there were also political issues of power, such as control over access to respondents. The discussion will now look at aspects of my relationship with, firstly, the respondents and secondly the gate-keepers.

Research relationships: rapport, vulnerability and power

Prior to starting the research, my concerns centred around the issue of developing rapport with the respondents. I wondered, as a feminist researcher, how involved I might become, or want to become, in other people's lives; how mutual or reciprocal information-giving should be; and to what extent would I, or should I, be able to preserve my detachment, impersonality, and anonymity (Burgess, 1982). I questioned the possibility of 'research subjects' becoming 'friends', and wondered to what extent a researcher could or should offer help, for example offering to baby-sit or helping with transport, as an acknowledgement of respondents' assistance with the research. While previous feminist research provide pointers on these issues, it has never been part of the feminist project to be prescriptive on the ways in which research should be conducted (Duelli Klein, 1983), and to a large extent I discovered that I had to find my own way through these dilemmas. For example, while the focus of the research was clearly not primarily ethnographic - that is, not concerned primarily with observing the women's everyday activities in the community - it shared elements of ethnography in that it was impossible (and undesirable) to separate the women's participation in the research from the rest of their daily lives. Thus, both epistemologically and methodologically, the boundaries separating 'research' from 'non-research' relationships and contexts tended to be permeable.

In relation to the conduct of the interviews, where respondents were interested in discussing my personal background, I answered all questions fully and honestly as part of a commitment to feminist praxis (Oakley, 1981a; Cook and Fonow, 1984; Finch, 1984; Stanley, 1990; Reinharz, 1992; Stanley and Wise, 1993; Maynard and

Purvis, 1994). The only questions I would not answer related to my surname and address, for security reasons. We often found that I had much in common with my respondents, for example they were often interested to know that I was a mother, and several wanted to know about my own substance-using experience, which I was happy to discuss with them when asked.

While conducting the interviews, I often brought with me cigarettes, lighters, biscuits, and little toys for their children. I sent the respondents attractive cards to make appointments or thank them. I gave some women flowers at the end of the interviewing. Towards the end of the fieldwork, when I made the final major push for respondents, I bought £5 telephone-cards and telephone-bill stamps to thank women for completing interviews. I baby-sat for one woman while she popped out on an errand. For women experiencing specific problems such as childcare problems, I tracked down the telephone numbers of appropriate agencies to contact. After completion of the research, I took one ex-respondent and her child to the circus, and supported another ex-respondent by accompanying her to social services' and solicitor's meetings and court hearings. These gestures of courtesy and support were to some extent dependent on the nature of the relationship established during the interviews, and varied according to the depth and length of interview process with that particular respondent.

These gestures of support and gratitude for their participation were given added impetus by my awareness of the respondents' vulnerability and need for support. The respondents were vulnerable in that many of them lacked confidence and self-esteem, and often mentioned feeling lonely, miserable, easily hurt, and hopeless about the future. They were also vulnerable in being liable to be socially isolated,

ill, in pain, impoverished, tired and possibly hungry, or homeless. A number of respondents at the time of interview were currently in abusive and physically violent relationships with male partners. For example, when I asked one respondent in conversation whether her current partner was raping her, she replied hesitantly, 'I don't know what rape is. Is it rape when they get you drugged so you don't know what you're doing? Or when they tell you enjoy it like that? Or when they don't care if you like it or not?' She concluded sadly, 'I don't know what it's *supposed* to be like any more, so I don't know if it's rape or not.' Other women talked about ex-partners they no longer loved, who continued to stay at their homes and demand food and other favours, with the threat of violence if the women did not comply. There was no recourse for these women, since they knew police injunctions would only increase the violence, and they refused to make themselves 'intentionally homeless' by leaving their family homes. As a researcher going into their homes, collecting data, and departing, I often felt helpless outrage mixed with intense respect for women who could continue to make a life for themselves out of such crushing adversity. The women understood that I was visiting them only as a researcher collecting data, and that I could offer them neither advice nor commitment. I could not solve any of their problems, but I could simply sit quietly listening to them with empathy and without judgement, and, as is the experience of other researchers (Finch, 1984; Kennedy Bergen, 1993), this seems at times to have been of value in itself, at least to some of the women.

Alongside these issues of rapport, research-boundaries and vulnerability, ran the related issue of the relationship with gate-keepers. Since access to this sample was largely controlled by professional gate-keepers, the perforce somewhat 'fuzzy'

nature of the research boundaries became a key element in the relationship with a small number of the gate-keepers. Particularly in view of the acute vulnerability of this client-group, gate-keepers had a clear responsibility to protect them from exploitation by unscrupulous researchers, or from direct or indirect harm and thus, in negotiating access and working with their clients, I took pains to explain the research process (and the implications of their agreement to participate) clearly in lay terms to all relevant members of the gate-keeping organisation. Whether accessed via gate-keepers or not, all respondents were made aware of the parameters of the research and were able to give their informed and voluntary consent. Respondents were informed that they were in control of the information-giving process, that the research was confidential and anonymous, and that the interviews would be taped (unless requested otherwise) and transcribed by a responsible person aware of the confidentiality of the subject-matter.

While the majority of gate-keepers were happy with the conduct of the research, and appeared comfortable with the methodology of qualitative research, one set of gate-keepers in particular struggled with this approach, and appeared to remain firmly entrenched in an aggressively positivistic and survey-based approach to research, so that they found it hard to understand issues of rapport and empathy between myself as a researcher and the respondents. For example, as a requirement of participation by their agencies, I was told that I had a duty to report any cases of child abuse I encountered, and that I must declare this duty to potential respondents prior to interviewing. Since this approach was unlikely to engender strong feelings of trust in respondents, and since a key area of the research was a focus on problematic mothering and the difficulties of parenting (and hence

encouraged respondents to be open about discrediting and shame-filled experiences of poor parenting), and since also this duty to report is one which is common to any member of the public, and since many children of respondents were already known to and monitored by social services, this requirement did not meet with my wholehearted endorsement.

Another requirement laid on me by this set of agencies was that I not participate in any activity not strictly within their definition of a researcher role. Thus, for example, I was warned against anything they regarded as ‘counselling’, and was thus required not to talk with distressed women on the telephone, or ‘counsel’ them in the interview setting. I was also forbidden to meet with respondents outside the formal research setting. Such requirements are at odds with the ethic of feminist praxis (Oakley, 1981a; Cook and Fonow, 1984; Stanley, 1990; Stanley and Wise, 1983, 1993; Reinharz, 1992; Maynard and Purvis, 1994) and moreover were clearly unworkable in the field, where respondents were often distressed during interviews, due to the painful nature of the subject-matter, and where informal encounters were an integral aspect of the research process.

The researcher’s response to distress in a research setting has been discussed in the literature (for example, see Rothman, 1986; Cannon, 1989; Renzetti and Lee, 1993), and Oakley (1981:41), for example, has stated categorically ‘when a feminist interviews women [the] use of prescribed interviewing practice is morally indefensible’. When women were distressed in my presence, I would respond by simply sitting quietly and listening empathically, which, as a qualified occupational therapist trained in counselling techniques, I knew to be the essence, coincidentally, both of good researching and good counselling. With the exception of one incident,

where I (inappropriately) stepped outside the research relationship in order to offer a two-week stay at my house for an extraordinarily distressed and unsupported respondent (an offer which was not taken up), it would be true to say that I probably entered *less* into respondents' lives than other researchers have at times done, who for example have exchanged Christmas gifts, accepted dinner-invitations, offered emotional support and counselling, or become part of a circle of friends with certain respondents (Oakley, 1981; Finch, 1984; Cannon, 1989; Kennedy Bergen, 1993; Taylor, 1993), but my participation was nevertheless perhaps more than these agencies felt was proper.

Thus this research project is probably unusual in the level of ethical complexity it has entailed, mainly because the sample was largely composed of women who were intensely vulnerable, needy for help, and in a number of cases not receiving the help they required. Alongside the ethical demands went emotional demands on myself as researcher, an aspect of the work of researching only recently beginning to receive attention (Rothman, 1986; Cannon, 1989; Duncombe and Marsden, 1993; Jackson, 1993; Ribbens, 1994). Although the fieldwork for this research project was, for much of the time, difficult and demanding, my enduring memory of the research is of the respondents themselves and of their pain, courage and tenacity in the face of overwhelming odds.

Analysis of the data

The large amount of information from interview transcripts and supporting data was analysed using the 'grounded theory' approach originally developed by Glaser and Strauss (Glaser and Strauss, 1967; Strauss and Corbin, 1997). Theory-building was constant throughout the years of gathering data on substance-using mothers.

The research generated a vast amount of interesting material and thus necessitated a selective approach in the choice of themes which could be explored. The selection of themes was guided by the existing literature; by the expressed interests and concerns of the research participants themselves (including the women respondents and the professionals involved in the field); by the MA theory-building; and by preliminary analysis of the whole data-set obtained by making notes at the time of the interviews, reading and re-reading the transcripts, listening to the tapes and checking the transcripts, and undertaking intensive line-by-line coding of a sample of the data.

The process of developing theory was one in which the interview data were never taken as a discrete and privileged corpus of information to be worked on in isolation: on the contrary, they were examined and analysed with continual and intensive reference to many other sources of data. Ongoing relationships with substance-using women and others in the field were used to inform the directions of analysis, and this was combined with study of the widest possible range of literature to help interpret the findings and also search for new aspects in the data. Thus the interview data took their place as only one, albeit central, part of the total research process, in which many resources were drawn on in order to begin to develop formal theory which can begin to explain the everyday experiences of substance-using women.

This method of working meant that coding the data represented only one section of the research process. The most helpful technique was to immerse myself in the transcripts as complete texts, preserving the flow of the women's narrative-accounts and the sense of events unfolding, reading the transcripts alongside other

research-reports and sociological and anthropological literature, and, one could almost say, using both of these sources equally as ‘data’ which was used to generate and test theory.

The search to develop more formal and middle-range theory related to substance-use and motherhood thus seemed to require a particular form of analysis of the data, at once broader (taking in many disparate theories and viewpoints from sociology, anthropology and elsewhere) and more intensive (focusing on the microscopic level of interactions and undertaking intensively detailed analysis of tiny segments of the data) than most researchers seem to have used hitherto when researching women substance-users. The method of microscopic data-analysis has been summarised by Agar (1991:190, 193,194) as:

‘critical micro-level work [which] requires looking at a few detailed passages, over and over again, doing the dialectic dance between an idea about how text is organized and a couple of examples, figuring out what [one] is looking at, how to look at it, and why ... That critical way of seeing ... comes out of numerous cycles through a little bit of data, massive amounts of thinking about that data, and slippery things like intuition and serendipity ... you need a little bit of data, and a lot of right brain’.

As with any analysis of qualitative data, questions arise as to the reliability and validity of the analysis, and the generalisability of the subsequent findings (Marshall and Rossman, 1995). That is, would another researcher, given the same data, reach the same conclusions? Does the theory developed from the data sufficiently explain the findings? Is this theory then able to say anything about the experiences of any

other people beyond the research sample?

These questions are not always addressed directly. Researchers may well explain how they obtained their data, but not how they then analysed them in order to reach their conclusions, or whether - and in what sense - their conclusions are generalisable.

For example, Avril Taylor, in her published study on women drug users (1993), takes pains to discuss her methodology clearly and fully in terms of her field research but remains silent on the actual process of analysing her data. Similarly, James Inciardi, writing about the experiences of researching crack-using women (1993), discusses the ethics and dangers of field research in crack-houses, but omits to discuss how the data, once collected, were analysed. Marsha Rosenbaum, in her study on heroin-using women (1981a), is more explicit. She was assisted by Anselm Strauss and used a pure form of grounded theory, with extensive use of coding and memoing of each transcript and theoretical sampling to address new issues as they arose. Once theoretical saturation had been reached, later interviews were used to verify emerging theory. This allowed her to identify a basic social process of 'narrowing options' in the lives of heroin-using women.

I find it unlikely to imagine that another researcher, given the same set of data, would come to identical conclusions as myself, since that researcher would bring to her analysis, as I have done, her situated standpoint which would make her more or less sensitive to the nuances of the data, just as it has done for me. For this reason, another researcher would be likely to produce different theory, although it seems likely that the basic themes would remain the same: one study at least (Armstrong et al, 1997) has found that different researchers show close agreement on

identifying basic themes within transcripts, even though they may present these themes differently. I am confident that my analysis is reliable and valid in that, working backwards from the generated theory to the original data, another researcher would recognise clearly how the theory is grounded in and derived from the substantive data. I am also confident that the theory is robust enough to be validated in further studies, and that the more formal aspects of the theory are generalisable in that they are able to throw light, not just on the experiences of other substance-using mothers, but also on the experience of motherhood more generally and on the experiences of other stigmatised groups.

Having outlined the main issues relating to the design and conduct of the research, the next two chapters provide a discussion on the two areas, respectively, of substance-use and motherhood, in order to constitute a backdrop against which an interpretation of the findings from the research can take place.



Chapter Three: Contemporary Substance-Use

Introduction

This chapter and Chapter Four will provide a theoretical context for the data by giving a brief historical overview of women's substance-use and the explanations for this behaviour and, in Chapter Four, providing a discussion of social understandings of motherhood, childhood, and their relationship with the State.

Before we can fully appreciate contemporary discourses around substances, we need to know the roots from which such discourses draw their sustenance. These roots stretch back centuries into Western culture, and in exploring their history we uncover the hidden history of women's relationship with substances. Far from being marginal or recent, women's association with psychoactive substances is in many ways more intense and more firmly culturally entrenched than men's, and provides a significant backdrop to the discussion of contemporary substance-use.

Having broadly outlined this historical dimension to substance-use, the chapter will turn to address the questions of why and how women use such substances, and what effects their use may have on themselves, their families, and society more generally. Thus the chapter discusses traditional medico-psychological and sociological theories of deviance, addiction, and dependence, and counter-poses these to more radical analyses from a predominantly feminist perspective, which offer a view of women's substance-use as rational and functional. From this framework, we can begin to make sense of the wider social response to substance-using mothers as often stigmatised and 'evil' mothers.

Historical background

As one author on the history of women's drug-use has observed (Kohn, 1992:1): 'Drugs have lost their history. A few antique episodes remain in popular consciousness ... But there is little sense of how certain drugs came to assume their special role, corrosive and Dionysiac, in twentieth-century culture.' As Kohn (1992:2) contends, 'the modern discourse about drugs is about far more than drugs ... Drugs permit the terrors of the social subconscious to be voiced. It is an eloquent panic.' These 'terrors of the social subconscious', historically and currently, are often linked to the relationship between women and drugs, whether in terms of social class and nineteenth-century fears of working-class maternal incompetence or bourgeois female pleasure-seeking (Berridge and Edwards, 1981), or in terms of 'race' and early twentieth-century anxieties over the seduction of young white women by Chinese or Black men (Kohn, 1992).

The roots of the current 'drug crisis', involving heroin, crack-cocaine and Ecstasy, were put down in the last century, with the introduction (through advances in medical practice) of cocaine, synthetic opiates and hypodermic syringes and, arising from that, the construction of a new category of deviant, the 'dope fiend' (Berridge and Edwards, 1981). The 'dope fiend' related to a moral rather than medical category, and was regarded as lacking the moral qualities of sobriety, which include being sane, rational, tranquil, sedate and moderate. The development of the compulsive drug-user as a category thus arose from earlier constructions of the 'drunkard'.

Drunkenness has traditionally been very much more frowned upon in women than in men precisely because of its moral attributes. The 'moral panic' of the Gin

Epidemic in the 18th century, which began when Parliament lifted restrictions on the production of domestic gin to boost revenue and lasted approximately from 1720 until 1750, was less about the dangers of alcohol use per se than about the loss of social control over the urban underclass, and in particular fears of female sexual laxity and the abandonment of maternal duty among working class women (Otto, 1981; Gomberg, 1982). The Gin Epidemic occurred at a time of accelerating social change, with rapid expansion of the urban underclass due to nascent industrialisation, and the growth of middle-income groups as the mercantile and professional classes gained in political importance over the land-owning elite (Macropaedia Britannica, 1992). Poised on the brink of vast social change, the concern with alcohol consumption seems to have provided a language which enabled the articulation of wider fears, among the elite and developing mercantile classes, about the problem of maintaining order, both in terms of class and in terms of gender. Gender in particular became an issue because of specific medical and social concerns about the impairment of women's childrearing ability, including damage to offspring in the womb and in the homes managed by drunken women. These concerns over mothering and substance-use are vividly captured in the well-known engraving 'Gin Lane' by William Hogarth (1751), reproduced at the beginning of this chapter and showing a baby falling out of its drunken mother's arms. When the Government reinstated a tax on domestic liquor-production, the Gin Epidemic and fears over maternal alcohol-use subsided, to be replaced in the next century with concerns over opium-use.

The popularity of opium since at least the early eighteenth century placed it, after alcohol, as the second most predominant form of psychoactive substance used by

the British population. Preparations from poppies, such as poppy-head tea and later opium (the resinous exudate from the poppy-capsule), had been widely used for generations for pain-relief and sedation, and was a common agricultural crop in England as well as being imported from Turkey and elsewhere. By the mid-nineteenth century, subsequent to the Industrial Revolution which necessitated increasing numbers of lower-income women working outside the home and hence leaving their children in the care of others, opium-based preparations seem to have become an increasingly significant part of daily life. This may have been because of the importance of settling children down and keeping them quiet and manageable, and perhaps also to compensate adults for the accelerated pace of factory-life and the anxieties of living through an unprecedented social upheaval. Whatever the explanations, opium and opium-based preparations such as paregoric and laudanum were used extensively, being sold in local general shops, and opiate-use generally was very popular among labourers and factory-workers as a cheap form of self-medication, especially for 'women's ailments' and to 'keep the womenfolk quiet' (Berridge and Edwards, 1981).

A shift in the popular perception of opium occurred with the Opium Wars of 1839-42 and 1856-58, and the increase of Chinese immigration into the ports of London and elsewhere. Opium gradually came to be linked not to the traditional European usage of eating or drinking opium-preparations but to the Chinese practice of opium-smoking, and thus to a discourse of 'race' and otherness (Kohn, 1992). Opium was also becoming linked for the first time to a discourse on class: the working-class were seen to be abusing opium by the practice of 'infant doping', and there were also concerns over its increasingly 'luxurious' use, for pleasure

rather than medication, among the working classes and the avant-garde of the 'naughty nineties'.

Towards the end of the nineteenth century, the State, motivated by public concern over infant doping practices, passed a series of measures to control the sale of opium-based preparations, and opium lost its traditional role as an everyday medication, but remained available to some extent for compulsive or recreational use. It was shortly joined by morphine, which had been isolated from opium in 1803, and could now be injected, using the recently-invented hypodermic syringe, by middle and upper-class women, who could afford the time, and the cost of doctors and medical prescriptions (Berridge and Edwards, 1981). Thus opium and morphine accelerated their drift to the margins of society, joined by heroin, first synthesised in 1898 as a cure for morphine-addiction (which had itself been used as a cure for opium addiction). At this time also cocaine, which had started life as a work-drug of the Andean Indians and been taken up by stevedores in the United States, was quickly adopted as a recreational drug by both bohemians and the underworld (Kohn, 1992). Drug-use by this point was fast approaching its modern form.

As opiate-use moved away from ubiquity and normality towards deviance and pathology it, like many other aberrant behaviours such as homosexuality, stealing, drunkenness or unmarried motherhood, traced a path of increasing medicalisation, from personal moral failure via a 'disease of the will' towards a clinically-recognised diagnostic category and a recognised medical disease, in this case 'morphinism' or 'narcomania'. It is noteworthy that throughout this process of medicalisation, linked to the rising influence of the medical profession, the whole

discourse around deviant drug-use was framed within a 'feminine' context - the elderly working-class woman using opium for her aches and pains; the un-masculine and more 'feminine' men on the margins of society, such as bohemian poets and Chinese foreigners; and paradigmatically the selfish and immoral middle-class woman injecting herself for pleasure with unwisely-prescribed morphine obtained from her doctor. Thus the British Medical Journal reported in 1902 (quoted in Kohn, 1992:18), under the heading 'Morphine Tea Parties given by Women':

'The fashion, which is said to have originated in Paris, consists of the formation of what may be termed a morphine club. A number of ladies meet about 4 o'clock every afternoon, tea is served, servants are sent out of the room, the guests bare their arms and the hostess produces a small hypodermic syringe with which she administers an injection to each person in turn.'

Newspaper reports similarly described the phenomenon of women increasingly using cocaine recreationally, so that within a few years the Evening News (1916) was able to assert that the use of cocaine, from being practically unknown a few years previously, 'has spread like wildfire in all classes of the community until, next to alcoholism, it is far and away the commonest form of drug-taking.'

Increasingly vigorous forms of social control, such as forcible detention in mental asylums under the 1913 Mental Deficiency Act, and later the criminalisation of both opium and cocaine in 1916, did not curb the explosion of recreational drug-use which now took place, and, throughout this first 'drug epidemic', the emphasis of social concern and social control remained on women, as both deluded victims

and evil temptresses. Cocaine in particular was regarded very much as a young woman's drug, from the middle and upper-class flapper to the working-class factory girl.

However, as the upheavals of the Great War of 1914-18 and the inter-war years ebbed away, society entered a new period of relative stability from the 1930s onwards, and drug-use correspondingly declined as a social phenomenon. The Second World War, curiously, did not witness a revival in the widespread use of cocaine or opiates. Opiate-use, despite the availability of the highly-addictive synthetic compounds morphine and heroin, and the increasing use of hypodermic syringes, failed to become a large-scale problem outside the limited confines of the medical profession. It never gained the popularity of cocaine, and the number of registered addicts on heroin prescriptions (mostly doctors) never exceeded four hundred until the 1950s (Winick, 1961). When widespread opiate-use did begin to reappear in the mid-1960s, it was initially treated with tolerance, under the 'British System' which regarded addiction as a primarily medical phenomenon and prescribed the addict their drug of choice (typically heroin). Inspired by a more 'militaristic' stance in the United States, however, policy quickly changed. The (exquisitely-named) Second Brain Report in 1965 heralded a dramatic legal crackdown, forcing drug-users into the criminal underworld. At the same time, the previous laissez-faire prescribing policy was replaced by the establishment of Drug Dependency Units, headed by consultant psychiatrists, who almost without exception declined to prescribe diamorphine (pharmaceutical heroin) and prescribed only methadone for opiate-addiction.

The Second World War also saw an increase in the use of Benzedrine (a form of

amphetamine), which was taken up particularly by the Mods in the 1960s.

Meanwhile, a vast increase in the prescription of barbiturates was taking place, especially for women suffering, in Friedan's (1963) words, from the 'feminine mystique' of the housewife trapped in the tensions of the age of women's liberation. The Valley of the Dolls (Susann, 1967) publicised for the first time women's hidden reliance on mood-altering pills. Promotion and sales of barbiturates and, later, benzodiazepines were fuelled by aggressive marketing strategies from companies such as Glaxo and Wellcome riding high on the wave of a 'revolution' in pharmaceutical developments.

The replacement of barbiturate prescriptions with benzodiazepines in the 1960s did nothing to slow this trend towards the consumption of psychoactive medication. Thus the pattern, from Victorian use of veronal to the 'Prozac nation' (Kramer, 1993; Wurtzel, 1995) of the 1990s, has remained stable: it is women who are the dominant consumers of licitly prescribed mood-modifying drugs.

The next major 'drug panic' occurred in the 1980s with the increased availability of cheap heroin (at the same time as HIV began to be recognised as a serious epidemic), and the enormous popularity of a manufactured drug, Ecstasy, linked with the development of the rave scene. Shortly afterwards, in the late 1980s, smokable cocaine - crack - made its appearance in British culture. Now, in the 1990s, amphetamines, opiates and crack are currently regarded as the three most common 'street drugs' used by women which give rise to dependency and other problems. Cannabis and 'rave' drugs such as Ecstasy and LSD are also widely used by young women (Measham, 1995) but appear to seldom be related to long-term problems such as dependency (Gilman, 1992, 1993; Shapiro, 1996). Having placed

women's contemporary substance-use in its historical context, the following section outlines some contemporary theories on how women use psychoactive substances today.

Contemporary sociological theories on women's substance-use

Because the term 'substance use' is not self-explanatory, I will open this discussion by defining the meaning of this term, and then move on to look at 'addiction' and 'dependence', before turning to an analysis of gender and dependency.

Throughout this thesis, 'substance use' is used to refer to the process of consuming any chemical which is psychoactive, that is, having an effect on the central nervous system. This includes chemicals which have a primarily stimulant effect (such as cocaine, amphetamines, caffeine or nicotine), or depressive effect (such as alcohol, barbiturates, benzodiazepines or opiates). These chemicals are also known as psychotropic, mood-modifying, or mood-altering drugs. Some chemicals, especially the opiates (substances derived from the opium poppy) or opioids (synthetic chemicals mimicking the effects of opiates) block physical pain as well as inducing a feeling of psychological well-being, and other chemicals, notably LSD, cannabis, Ecstasy and hallucinogenic mushrooms, may alter perceptual function.

Any psychoactive chemical may or may not be considered to be physically addictive. It may or may not also be considered to induce craving and thus psychological dependence. 'Addiction' is generally defined (for example, see Davies, 1991; Pagliaro and Pagliaro, 1996) as an objective physical state in which the body has become physiologically accustomed to the presence of the substance, and there are symptoms of physical illness such as sweating, shivering, aching and

diarrhoea when the level of substance in the body is reduced. This state of physical malaise is termed 'withdrawal'. As the body becomes accustomed to the substance, tolerance develops, so that increasing quantities of the substance are required to stave off the onset of withdrawals, as the substance is metabolised by the liver into non-pharmacologically-active metabolites. Substances that are currently considered to be physically addictive include opiates and opioids, barbiturates, benzodiazepines, nicotine, caffeine, and alcohol. For addiction to develop, use of the substance needs to be sustained, as addiction and tolerance are considered to develop only with repeated use.

Psychological dependence is considered to differ from physical addiction (although the two may co-exist) in that the main symptom is intense craving in the absence of physical changes to the body. The primary motivation for continuing to take the substance may be either for the psychoactive effects, such as lifting mood, or else to stave off the symptoms of withdrawal (Lader, 1979). Substances that are currently considered to be primarily dependency-forming rather than physically addictive include the amphetamines, cocaine (including crack) and cannabis.

Hallucinogenics such as LSD and Ecstasy do not appear to show these patterns of leading to either addiction or dependency.

Of note to sociologists is the fact that the terms 'addiction' and 'dependency' are not clear-cut, and implicitly allow fluidity and ambiguity in their definitions and interpretation. Over the past century there has been an enormous proliferation of theories on addiction, all of which seem mutually incompatible and none of which appear to have led to accurate prognosis or effective treatment. To further muddy the waters, the concept of 'addiction' has been stretched to its logical limits by the

recent use of terms such as addiction to shopping, to gambling, to love, to relationships, to food, to sex, to exercise, to work and so on (Giddens, 1992).

What is being described here relates to compulsive behaviour or 'excessive appetites' (Orford, 1985) without any necessary physiological component - unless the substance of addiction in this case is actually self-produced adrenaline or endorphins. Again, even allowing that there is a conceptually distinct category of physical 'addiction', there is clear evidence that the physiological components of addiction are profoundly affected by the user's expectations and the setting within which the substance is taken (Claridge, 1970; Zinberg, 1980), as evidenced by addiction to placebos (Lancet editorial, 1972), the ease with which Vietnam veterans gave up their heroin addictions on return to civilian life (Peele, 1978), and the fact that heroin addicts, switching to amphetamine during a heroin 'drought', continued to respond in exactly the same way to amphetamine, a stimulant, as to heroin, a depressant (Jackson, 1978).

There would seem to be literally thousands of theories on addiction developed since interest first began to be shown in the subject by psychiatrists in the nineteenth century, and it appears that the field of 'addiction studies' may still be in a 'pre-paradigm' state with no leading theory (Shaffer and Burglass, 1981).

One overview (Pagliaro and Pagliaro, 1996) found 'several hundred' recent theories on substance-use simply in children and adolescents alone, developed from the disciplines of biology, psychology and sociology. Briefly, biologically-based theories tend to emphasise neurochemical, metabolic and genetic factors (Glueck and Glueck, 1950; Seeley, 1962; Vaillant, 1983), while more psychological or sociopsychological theories tend to draw on psychoanalytical concepts such as oral

gratification (Chein et al, 1964), Jungian death and initiation rituals (Zoja, 1989) or, more recently, object relations (Volkan, 1994); trait or drive theories such as addiction-to-pleasure (Bejerot, 1972), sensation-seeking (Segal, 1974; Jessor and Jessor, 1977; Zuckerman, 1979; Tonkin, 1987), or self-destruction (Hertzman and Bendit, 1975); developmental theories, arguing for a 'natural history' of drug use (Robins et al, 1975); and social learning or cognitive-behavioural theories (Akers et al, 1979). Theorists also draw on family systems theory, viewing the substance-user as serving the function of maintaining 'balance' in the family (Stanton and Coleman, 1980), much as incestuously-abused children have also been regarded by certain family system therapists (Kaufman et al, 1954; Waldbury et al, 1989).

The central debate in the field of addiction studies revolves around the question of whether or not addiction can be conceptualised as a 'disease'. While some models do not accept a disease definition of substance use, preferring a focus on 'destructive habits' (Peele et al, 1991) and indeed 'appetitive behaviours' (Orford, 1985), the most widely-used theories in clinical practice remain those that are based on a disease model, including the Twelve Steps of Alcoholics Anonymous (and its many derivatives), the 'Minnesota Model', and the McAuliffe and McAuliffe model of chemical dependency, which views substance dependency as a peculiar form of disease - a 'relational disease', or pathological relationship which a person has towards a psychoactive substance (McAuliffe and McAuliffe, 1975).

The advantage of disease-based theories such as these is that they are able to offer a decisive and unambiguous view of reality, often founded on a Christian worldview, which provides a satisfyingly coherent diagnosis and treatment plan. Such biological and psychological theories are therefore used principally as

treatment models. In contrast, purely sociological theories have been less used as professional tools, and have traditionally tended to focus more on explaining and thus legitimating the position of the substance-user, rather than developing tools for diagnosis and treatment.

Sociological theories related to substance-use flowered predominantly in the 1960s, mainly connected with the Chicago School's intense interest in understanding and explaining deviant behaviour (for example, see Erikson, 1962; Kitsuse, 1962; Becker, 1963a, 1963b, 1964; Schur, 1964, 1965, 1971; Lemert, 1967; Matza, 1969; E. Goode, 1972; Szasz, 1975), fuelled by the exponential increase in drug-use in American society, which shifted explanations for drug-use from individualised psychopathology to sociological analyses of inter-personal interaction within a social context. For example, Winick, writing extensively from the 1950s to the 1970s, used role theory and role strain to account for drug dependence (Winick, 1962). Chein et al, in The Road to H (1964) argued that opiate addiction can be an adaptive, functional and dynamic response to feelings of stress. The importance of peer-groups and group norms was recognised with Johnson's (1973) theory of a 'drug subculture' with its own distinctive values, norms and roles, while Zinberg and colleagues developed a social control theory of drug use, focusing on how 'the drug, the set and the setting' interact to modify and control drug-use, governed by complex patterns of internalised sanctions and rituals (Zinberg, 1980).

However, the great majority of this research paid little attention to the distinctive experiences of women, arguing either that women comprise only a tiny subset of substance-users generally (Ellinwood et al, 1966; Polit et al, 1976; Martin and

Martin, 1980; McGrath, 1982; Auld et al, 1986) or, alternatively, that there are no essential differences in the experiences of women and men users (Christmas, 1978; Fuller, 1978). As Inciardi et al. (1993:17) note, although ‘intensive research on substance abuse can be traced back at least sixty years, the great bulk of existing work is concerned with either male alcoholism or male heroin addiction.’

Such a ‘single sex’ or gender-blind approach is of course not limited to the field of substance-use, but has been widespread throughout the social sciences (for example, see Oakley 1974a, 1974b). The result has been, however, that research thereby neatly ignored both the widespread prevalence of polydrug use (the problematic use of several different psychoactive substances at around the same time) and women’s experiences of substance use.

Where women did feature in research they were often characterised as ‘sicker’ than their male counterparts - self-destructive, unstable, sexually maladjusted, immature, and inadequate (for comments on this, see Perry, 1979; Ettorre, 1989; Roth, 1991; Inciardi et al, 1993; Taylor, 1993). This can partly be explained by their greater levels of emotional distress and (often undisclosed) histories of previous sexual abuse (Wallen, 1992). However, this view of women users as ‘sicker’ militated against their inclusion into a less pathological model of substance-use, despite the fact that perceptions of male users had moved fairly rapidly from a clinical emphasis on social inadequacy (see, for example, Cloward and Ohlin, 1960 and Chein et al, 1964) to an understanding - derived from ethnographic research - of male heroin-users in particular as resourceful, competent and active (Finestone, 1957; Sutter, 1966; Feldman, 1968; Preble and Casey, 1969; Hughes et al, 1971; Agar, 1973; Waldorf, 1973; Fiddle, 1976; Hanson et al, 1985; Johnson et al, 1985;

Williams, 1989). The lack of ethnographies on women users (with the exception of Rosenbaum, 1981a) meant that such a shift in the perception of women has been delayed until the 1990s (Taylor, 1993).

Even now, where women are the focus of research, it is still often only during or immediately after pregnancy, where the impact of their substance-use on the foetus or baby is the prime concern (Inciardi, 1993; Kline, 1996; Lemieux, 1996). As Colten (1982:78) notes, 'Entire conferences and monographs on the addicted mother and her family have appeared with barely a mention of the mother. She is viewed as an independent variable - as the source and never the victim of the problem'. Other studies which have looked at the situation of substance-using women have usually done so more as a by-product of interest in HIV infection (for example, see Plant, 1993). The situation described by Perry (1979: 4), that 'the extent, context and experience of female drug use remains invisible' continues to be largely true today, but has now begun to be addressed, with several impressive studies conducted on the experiences of women drug-users (Rosenbaum, 1981a, 1981b; Colten, 1982; Taylor, 1993; Inciardi et al, 1993; Kearney et al, 1994; Lewis et al, 1995; Powis et al, 1996). While this is so for illicit drug-use, both empirical studies and attempts to develop a theoretical framework for addressing the issues of women and alcohol continue to remain fairly thin on the ground (Ettorre, 1997; Plant, 1985, 1997; Thom, 1997). Meanwhile, researchers such as Inciardi et al (1993:21) continue to plead for research which are not 'single sex - single drug' studies, but use a cross-drug comparative analysis and pay attention to the linkages between drug use and other socially problematic behaviours.

Another enduring problem for research in this field has been that, to date, most

studies have focused on treatment populations, and this has led to a dearth of research which takes full account of women's everyday social settings and social relationships (but see Rosenbaum, 1981a and Taylor, 1993). Again, most research so far is from the United States and much of it is dated. Since substance-use is highly context-dependent and rapidly-changing, reliance on studies from other countries and other decades can only give a very partial understanding of contemporary issues. The current situation in Britain, since the 'heroin epidemic' in the 1980s, has been addressed by a handful of social scientists (Dorn and South, 1987; McKeganey and Boddy, 1987; Parker et al, 1988; Pearson, 1987; Morrison, 1989; O'Bryan, 1989), but only one study within this focuses specifically on the everyday life experiences of women (Taylor, 1993).

No research on women and substance-use can go far before encountering the question of normative female roles and the perceived deviance that substance-use among women entails. The use of illicit substances (and the risk-taking involved) can be construed as *compatible* with normative male roles, and thus by contrast *incompatible* with normative female roles, thus the deviant use of substances is highly likely to be perceived as a specific form of gender-role deviance when women are involved. This specific perceived role deviance brings into question the totality of a woman's gender-role conformity, that is, implying the existence of still other violations of role norms such as loss of sexual inhibitions (Gomberg, 1982) and, essentially, her 'moral and psychological suitability for motherhood, of which the archetypal opposites are sexual promiscuity and emotional instability' (Inciardi et al, 1993:23). Even a limited number of substance-use episodes may act to spoil a woman's entire social identity, stigmatising her as 'wild, promiscuous [and]

unstable' (ibid.), leading to damaged relationships with her social network, loneliness and isolation (Cuskey and Wathey, 1982; Kroll, 1986). Thus women substance-users are not only perceived by researchers and others (as noted earlier) as 'sicker' than male substance-users, but also may perceive themselves in this way, particularly since they also often hold 'traditional' gender values (Rosenbaum, 1981a, 1981b; Colten, 1982; Parker et al, 1988). This conflict between women's norms and their deviant behaviour can easily lead to lowered self-esteem (Colten, 1982; Dorn and South, 1985; Gossop, 1986).

In addition to this widely-held view that substance-use, and especially excessive and illicit substance-use, is incompatible with normative female roles, a range of theorists have contributed other insights into our understanding of women's substance-use, which begin to build a more complex and paradoxical picture of the relationship between substance-use and gendered roles.

Many studies on women and substance-use from the 1970s onwards were intrigued by the finding that, from adolescence and throughout adult life, twice as many women as men were using tranquillisers such as Valium (Cooperstock and Parnell, 1982) and sought explanations (Riska, 1989), often in terms of women's normative female roles. Thus Cooperstock (1971), studying women's use of prescribed mood-modifying drugs such as tranquillisers, found that on the whole substance-dependency conformed to normative gender roles in that women are permitted greater freedom than men to recognise and express their negative feelings, which enables women more easily to define their difficulties within a medical model and bring them to the attention of the medical profession, resulting in greater consumption of mood-modifying drugs. She later widened her analysis

(Cooperstock and Lennard, 1979) to consider the ways in which tranquilliser-use assisted maintenance of a given social role which was experienced as being otherwise difficult or intolerable to maintain. Substance-use in her view thus works to sustain strained social systems, and it is interesting that many women in Cooperstock's study reported initial tranquilliser use following the birth of their children, or subsequent to widowhood or separation, which Cooperstock relates to the strain of adapting to a new role.

This insight was confirmed by other studies. For example, like Cooperstock, Helman (1981) identified one reason for taking psychoactive medication long-term as maintaining or improving relationships within the family. As he states (1981:527), 'for some patients the drug was taken as much for the benefit of others, as for their own benefit.' Often the drug was seen as helping users to conform to an idealised normative model of behaviour. Thus Helman found the drug enabled their social personae to function, much as fuel enables a machine to operate adequately. Without the medication, users felt both their psychological health and their relationships would disintegrate. Similarly, Prather's study of women taking tranquillisers (1990) gave little indication of tranquilliser-use being at odds with normative gender roles. Rather, she found endorsement for women's tranquilliser-use among their physicians, families and friends, and 'most users felt that spouses, children, and friends supported their use of the drug and often directly encouraged its use' for example by pinning up notes saying 'Mommy, it's time to take a happy pill.' (1990:311).

Thus women's reliance on psychoactive substances can be seen as compatible with her normative female role, in fact assisting women in smoothing over and coping

with the problems of role strain. However, more explicitly feminist analyses have highlighted how women's substance-dependency, although it may assist them to conform to stereotypical roles in society, may simultaneously and paradoxically lead to stigmatised deviation from such roles (Perry, 1979; Gomberg, 1982; Ettorre and Riska, 1995). Thus, while Andrea Dworkin (1983:158-9) has suggested that 'the female is valued for looks and domestic, sex and reproductive work, none of which requires that she be alert. She is given drugs because nothing is lost when she is drugged', other writers, while agreeing that 'an acceptable degree of passivity and dependence' (Perry, 1979:1) consonant with prescribed drug-use does constitute part of normative feminine characteristics, nevertheless point out the ambiguities and tensions which result from female over-dependence on psychoactive substances, which then undermine another key feminine characteristic - that of 'responsible self-supervision' in women's major role as responsible for family life, including housework, childcare, emotional support and family servicing (Perry, 1979:1). Gomberg (1982) also links social disapproval of women's over-use of psychoactive substances (from prescribed medication to alcohol to opiates) to the impairment of the nurturant and caretaking role. She concludes (1982:22) that:

'Drug and alcohol abuse among women is a political issue, linked to gender roles, power, ambivalence, and hidden anger and fears. ... The idea that intoxication impairs women's primary responsibility, her nurturing role, reaches its current expression in campaigns of fear about "neonatal addiction" and "the fetal alcohol syndrome".'

In the light of this ambiguity, where women's substance-use may simultaneously be

viewed as enhancing yet impairing adherence to normative feminine roles, it is interesting to turn to another body of work on women and substance-dependency, in this case Hilary Graham's work on women and cigarette-smoking.

Like tranquilliser-use (Koumjian, 1981; K. Graham and Vidal-Zeballos, 1997), contemporary cigarette-smoking is an activity linked to both social class and gender (Graham, 1989, 1994, 1995). Using demographic data from national surveys such as the General Household Survey, Graham has identified a key subset of cigarette smokers - young White women living in poverty and caring for others, often single mothers caring for small children (Graham, 1993a, 1993b). This subset of smokers is likely to smoke heavily, and to perceive specific benefits from their smoking, such as helping them to mark out time for themselves, and helping them to relax when feeling on edge (Graham, 1993a). In this way cigarette-use can be seen as assisting this group of women to comply with the almost intolerable demands of their social role as mothers coping and caring with few resources or support (Graham, 1987a, 1987b). In an earlier study of pregnant smokers, Graham (1976:403) found that smoking:

‘provides both a sense of body autonomy and role distance, a time when children are forbidden to climb on mother’s knee and to demand attention. It emphasises her adult status and her independence from her children, a function it serves not only with respect to her peers but also her husband’.

At the same time, mothers’ cigarette-use constitutes a social problem, in that there is clear evidence of health-related and economic harm to both the women and their children from the women’s smoking (Marsh and McKay, 1994). The evidence from

studies of women's cigarette-smoking thus again demonstrates the paradox that women's substance-use may simultaneously challenge her ability to adhere to normative nurturing and caretaking roles, while pragmatically enabling her to continue to perform those roles, which may well be perceived as intolerable without support from her substance-use.

If we turn now to look at theories on women's use of street drugs, we find that there are only a small number of studies conducted to date specifically on women's everyday life experiences. The first study of its kind was the groundbreaking series of interviews by Rosenbaum, in the United States, for her doctoral thesis in 1979, recruiting a community sample of one hundred women heroin 'addicts' through local advertising and snowballing, with a \$20 remuneration for participation. The interviews lasted up to three hours, using a life history approach, and Rosenbaum also conducted ethnographic fieldwork, visiting women at home and accompanying them on their daily drug-related errands. Her sociological analysis was the first to identify a career of 'narrowing options' funnelling the 'addict' further and further into a deviant lifestyle and making re-entry into the conventional world increasingly hard to achieve. Unlike male addicts, Rosenbaum (1981a:132) suggests that women experience a much sharper narrowing of options, again linked to a greater perception of deviance, so that when women use illegal drugs, 'she alone is defined as "damaged goods"'. ... The man is seen as having temporarily transgressed, whereas the woman is defined as having permanently fallen'. Despite this experience of greater stigmatisation, she found that women were actively and independently engaged in the drug lifestyle, and that as mothers they shared more in common with other non-addicted mothers (for example, concerns about

childcare and housekeeping) than they did with their heroin-using male peers.

Colten (1982), again in the United States, in a comparative study of 170 addicted (opiate-using) and 175 non-addicted mothers, also stressed the similarities between the two groups, with the major difference being addicted mothers' higher levels of doubt about their maternal adequacy. Colten (1982:83, 91) identified a clear pattern of 'fear of inadequacy, inability, and lack of control in childrearing' among addicted mothers, which led to an overwhelming although often 'unrealistic' sense of failure.

Such studies of American opiate-using mothers in the 1970s can be of only limited application to contemporary mothers in the West Midlands, living in radically different cultural, social and economic contexts. The most significant British sociological study to date has been Taylor's (1993) Glasgow-based urban ethnography of a female injecting community, drawing on fifteen months of participant observation of a community of over fifty women and on in-depth interviews with twenty-six women to develop a grounded theory analysis of the women's everyday lives. Taylor found, like Rosenbaum, that women drug-users are competent, rational actors, energetically pursuing their goals of drug-taking and, where they had children, mothering, and again that in many ways drug-using women with children shared more experiences and values in common with non-drug-using mothers than with their male counterparts.

The models so far reviewed, of substance-use generally, tranquillisers, cigarettes, and street drugs, have helped to bring into focus the coping function of substances, assisting women to perform their normative female roles more easily, and at the same time the stigmatising function of perceived over-use of psychoactive

substances when women's normative roles are seen to be impaired by their use of substances. These findings from research link in with the feminist concerns listed in the previous chapter, which pointed to the necessity of placing any understanding of women's substance-use within a social context which took into consideration the impact of patriarchy, normative notions of femininity, gendered role strains, cultural expectations of women as acceptably weaker and more dependent, and women's experiences of and reactions to trauma such as childhood sexual abuse and domestic violence. Also, as noted, a number of researchers have recently begun to stress another important element - that taking psychoactive substances can be very pleasurable (Stewart, 1987; Mugford, 1991; Ettorre, 1992; Henderson, 1993a, 1993b). As well as structural concerns, therefore, feminists have been keen to see the question of agency emphasised more in discussions on women and substance-use. Rather than viewing women users as either struggling conformers or stigmatised outsiders, they prefer to stress the fun aspects of substance-taking, for example by studying the recent rise in sophisticated and controlled recreational drug-use by young women on the rave and club scene (Henderson, 1993a, 1993b; Measham, 1995).

Thus this overview of women's substance-use leaves us with a sense of macro and micro-level pressures on women arising in large part from gendered role expectations. Women take psychoactive substances in order to perform acceptably and not deviate from normative feminine roles, and yet the taking of such substances may in itself threaten their role performance and result in their being labelled 'deviant'.

What issues remain to be addressed?

As noted earlier in this chapter, there would seem to be a striking lack of consensus yet among theorists over what ‘addiction’ or problematic substance-use is, how it is caused and how to treat it. Shaffer and Burglass’s (1981) point that the field of ‘addiction studies’ is in a ‘pre-paradigm’ state with no leading theory still holds today, and this lack of a clear theoretical direction seems to result in three related consequences.

One consequence is the fragmented nature of the field. With few exceptions (Ettorre, 1992; Ettorre and Riska, 1995), there is remarkably little cross-referencing between all the many bodies of literature dealing with the various aspects of substance-dependency. Thus the studies on tranquilliser-use, cigarette-use, alcohol or street-drug use each appear to stand alone and show very little evidence of cross-fertilisation, and the plea by Inciardi and his colleagues for studies which are not simply focused on ‘single sex - single drug’ issues (1993:21) continues to fall on deaf ears. Similarly, while studies such as those by Cooperstock and Lennard (1979), Cooperstock and Parnell (1982), and Graham (1976, 1987b), for example, may be linked to wider theoretical debates such as women’s role in society there is still little formal theory-building and little attempt to locate such studies into more over-arching theoretical models of power and dependency. Conversely, theoretical studies which do link together wider concerns, such as the commodification of pleasure (Mugford, 1991) or notions of motherhood and punitive legal responses to women’s drug-use (Perry, 1987; Chavkin, 1990; Drucker, 1990; Maher, 1990, 1992; Harrison, 1991; Keyes, 1992; Siegel, 1992; Peak and Del Papa, 1993; Beckett, 1995; Murphy and Rosenbaum,

1995), rarely tie these into a framework which incorporates licit substance-use such as tranquilliser, alcohol or cigarette-use. Thus this study appears to be among the first to attempt explicitly to tie together the findings from all these fields of study in order to begin to build a coherent theoretical account from these many disparate but highly relevant elements.

The second consequence, arising from the first, is the absence of critical and detailed analysis of earlier work. The key studies by Rosenbaum (1981a) and Taylor (1993), for example, are often referenced in the literature but there is little evidence of their findings having been analysed or theoretically advanced. Much of the material from my previous and current study (for example the fact that many women are already mothers when they begin using heroin) had already been at least indicated by both Rosenbaum and Colten in the late 1970s, but could as easily have been original to me, from the lack of impact which these findings have had on theory or practice. Again, Taylor in the 1990s reiterated similar findings to Rosenbaum's, such as drug-using mothers' childminding difficulties, but without tying these findings into any sustained discussion of earlier work. The absence of a central cross-disciplinary theoretical model of substance-use, and the proliferation of many disparate models within psychology, psychiatry, sociology and so on, compound the difficulty of building on earlier theory in order to test and advance it. This may be an advantage since, as Becker (1986) and Strauss and Corbin (1997) have argued, reliance on previously-developed theoretical models from the literature, rather than the generation of fresh insights directly from the data, may stultify and distort theoretical analysis. However, the result is again one of fragmentation of theoretical development, even within one discipline such as

sociology or women's studies.

The third consequence arising from the 'pre-paradigm' state and concomitant fragmentation of cross-disciplinary working and theorising is the lack of impact which research so far seems to have made on practice. To take a case in point, it would seem that sociological studies have made curiously little impact on clinical treatment despite, for example, the significance of their discoveries on the centrality of the motherhood role. The lack of integration of research findings into clinical practice is a problem not limited to the substance-use field, of course, but I would suggest that greater theoretical agreement on the definition and therefore treatment of substance-use problems would allow research and clinical practice to collaborate more closely and effectively.

This study is an attempt to overcome the fragmentising tendencies within the substance-use field, by deliberate use of as wide a range of theoretical resources as possible, drawing on the fields of anthropology, medicine, psychiatry and women's studies as well as sociology, and building on established theory by using earlier theoretical insights as one aspect of data within a grounded theory framework. In addition, the study locates the discussion of women's substance-use within an explicitly feminist framework in order to address macro-level, structural, elements bearing on women's experience of their gendered social roles, and to bring into focus their response as rational and competent social actors working to minimise their perceived role strains and maximise their sense of well-being and pleasure.

In this way the four 'unanswered questions' identified from the literature review in Chapter One are able to be tied into broader theoretical concerns. The thesis addresses these unanswered questions - on substance-using women's upbringing,

the texture of their everyday lives as mothers raising families, their interactions with their children, and on the functions substances play in their lives - at three interconnected levels of theorising. These levels range from the empirical and substantive level through the generation of concepts and identification of basic social processes up to a more formal level of theory-building which is able to situate the women's experiences and perceptions within a wider interpretative framework incorporating an analysis of patriarchy and its manifold effects on women's lives.

The following chapter takes forward this project by foregrounding the experience of motherhood, investigating its social construction and exploring the related concept of childhood, and the response of the State to issues such as juvenile delinquency, child abuse, and 'problematic motherhood'.



Chapter Four: Contemporary Motherhood

‘The future destiny of the child is always the work of the mother.’ (Napoleon Bonaparte)

‘All that I am or hope to be, I owe to my angel mother.’ (Abraham Lincoln)

Introduction

The whole concept of motherhood and mothering is simultaneously over-sentimentalised, under-researched and under-theorised: the question ‘What is a mother?’ is - even today - more likely to conjure up rosy Victorian notions of Mothering Sunday, lullabies and self-sacrifice than the everyday social and economic realities of reduced employment options, individualised responsibility, and what is, for many, the grinding tedium of childcare and housework.

This study of substance-using mothers as one example of ‘problematic’ mothering enables us to highlight theoretical and empirical issues concerning the practice of mothering generally. How a society views motherhood is significant on many levels. Ideologies about motherhood and mothering are critical to many key debates in contemporary society, for example around workforce legislation, welfare issues, and reproductive technology and so on (Glenn et al, 1994) but, in a far more immediate sense too, notions of motherhood touch on all our lives whether as mothers ourselves, as partners or relatives of mothers, or as once-mothered offspring. Once embarked on, mothering, as opposed to fathering, is seen as a lifelong occupation. As Masson (1995:210, emphases in original) has summarised it: ‘*to mother* a child is to cherish, care and nurture but *to father* is to procreate. Whereas nurturing lasts beyond childhood, fathering is a single act.’

Motherhood is not and never has been a static concept. Like the concepts of childhood and family, the expectations of motherhood are shaped by the prevailing

social climate, and yet, within that, whatever constellation of qualities define motherhood at that time is held to constitute some essential and immutable truth about motherhood. In many ways motherhood is an economic category, shaped by prevailing modes of production, as can be seen in the differing constructions of motherhood as Europe moved from an agrarian-based economy to an urbanised, industrialised, wage-based economy, with the coming of the Industrial Revolution, lasting in Britain from approximately 1770 to 1840. In this century, key influences on the ideology of mothering have been the continuing vision of 'angel in the house' derived from Victorian bourgeois ideology which itself drew inspiration from the Evangelical revival of the 1790s (Hall, 1979) and, more recently, the development of psychology, influences which will be explored more fully below.

It is clear that much of our current notion of mothering in the West is based on the normative white, heterosexual and married, middle-class, full-time mother. This hegemonic construction obscures and fractures competing constructions of mothering which have of course also always existed. For example, it obscures the experiences of Black and lesbian mothers, 'lone' mothers, and working-class mothers. At the same time the hegemonic ideal also assumes that all mothers love their children and act responsibly and consistently towards them, putting their children's needs before their own, however such needs may be culturally defined at any particular historical point in time. This prescription of motherhood performs two functions: it makes 'failure' or 'deviance' from this norm logically possible, while simultaneously defining such transgression as impossible - any mother who does transgress, for example by not loving her children, forfeits her right to remain in the category 'mother', she is 'not a real mother', she is 'unnatural'. Exclusion

from the category of mother - or contested legitimacy to membership of the category - carries penalties, and some of these will be explored in this chapter and through discussion of the research data.

The main purpose of this chapter, therefore, is to focus specifically on the common-sense everyday doing and being of motherhood, with the overall aim of placing substance-using mothers within their context as one subset in the larger category of contemporary motherhood.

Correlates of contemporary motherhood

Motherhood is a fluid social construct, varying with political, economic and cultural ideological changes. These changes may be mediated through formal processes, for example government action to establish or close work-place nurseries; the level of 'mother's endowment' or 'child benefit' which is paid; or local authority housing policies for pregnant women and families. The process of change may also be mediated through a host of more informal and subtle mechanisms, such as through the work of Victorian 'lady visitors' and, later, social workers; clinical interactions with medical and nursing staff, psychologists and psychiatrists; or the dissemination of ideologies via popular media or casual social interactions. Thus, whether at the macro level of State policy or at the micro level of face-to-face interactions with a midwife or a neighbour, through reading popular magazines or listening to conversation at the hairdresser's, notions of motherhood are constructed, disseminated, received, negotiated, adapted and contested in a continuous process of revision and development.

Within this fluid process of change and negotiation, we can discern certain key themes which identify and define our contemporary notion of ‘motherhood’ (as distinct from either ‘womanhood’ or ‘parenthood’). One major theme is that of mother-love. Love as a core component of motherhood has, particularly over the preceding two centuries, come to be understood as a biological given, a feminine instinct celebrated in hymns and poems, psychoanalytic theories, educational texts, women’s magazines and social policy, in a pervasive understanding that ‘all normal women love their children’. However, it can be argued that ‘mother-love’ is a social construct, not a biological given (MacIntyre, 1976; Rich, 1977; Badinter, 1981), and insofar as it is a normative construct within motherhood, which all normal and non-pathological women are expected to feel, love can be viewed as a responsibility of motherhood - mothers have a socially-constructed *responsibility* to feel and express love for their children. The evidence for mother-love as a social construct comes from the work of historical theorists such as Aries (1962), Shorter (1975) and Badinter (1981), who all give evidence for the shifting nature of parents’ attitudes towards their children over historical time.

For at least the preceding two centuries prior to the birth of the modern family in the 1760s, children in Europe had been routinely treated with hostility and fear, since they were regarded as steeped in original sin, necessitating merciless and violent discipline (Badinter, 1981). When not regarded as wicked or bestial, children were simply treated with indifference, regarded as a toy - an amusing plaything with no real personality - or as a machine, ‘an automaton, with neither a life nor a soul’ (Badinter, 1981:53). A significant consequence of this view of children as naturally sinful was the lack of desire to spend time with them: children

were frequently sent away to wet-nurses when only a few days old. Again, since children were regarded as essentially valueless, there was little medical interest in childhood illness - the term paediatrics was not even coined until 1872.

Thus the care of children up to the 1760s was experienced as neither pleasurable nor important, simply 'an embarrassing burden' (Badinter, 1981:71), and any form of strong parental love would have seemed anomalous: as one contemporary writer (quoted in Badinter, 1981:60) expressed it in the late 18th century, 'Too much caring would have seemed pedantic; affection too often expressed would have seemed something new and consequently ridiculous.' However, a fundamental shift took place in public conceptions of childhood between 1760 and 1770, linked in particular to the publication in 1762 of Rousseau's *Emile* (1993) which is widely credited as launching the ideology of the modern family based on mother-love.

Linked to the rise of a bourgeois-based manufacturing economy, the bourgeoisie from the eighteenth century onwards took over from the aristocracy the dominant role as the promulgator of domestic ideology, and they placed motherhood as its centrepiece (Lasch, 1977). Thus, as Shorter (1975:279) has expressed it, 'Maternal love created a sentimental nest within which the modern family ensconced itself.'

With this new conception of the responsibilities of motherhood - to love their children, to nurture and educate them, in brief to be there constantly for them - came, for the first time, an awareness that one could *fail* at these responsibilities. A whole new possibility was opened up: maternal guilt. Already by 1763 doctors were admonishing women 'Women are the agents through whom men become either healthy or sickly: through whom they are useful in the world or becomes plagues on society.' (quoted in Badinter, 1981:151). Such warnings, tediously

familiar to our ears, astonished 18th century society as compellingly original, and galvanised it into action. Increasingly, mothers were required to offer ‘proofs of love’ for their children, to demonstrate self-sacrifice and devotion. The father’s involvement in his children, meanwhile, became increasingly marginal, representing the more abstract values of law and authority and inculcating morality and good citizenship in his children simply by his own example. But for mothers, over the course of one generation, Badinter (1981:178) asserts, ‘[n]ot to love one’s child had become an inexplicable crime. A mother was loving - or she was not a real mother.’ This view of motherhood, once established, remains essentially the same even today.

The underlying premise, from Rousseau onwards, has been that motherhood is intrinsically rewarding, pleasurable and unproblematic for women. This view has received significant endorsement from psychoanalytic theories which have developed an understanding of motherhood as a normal characteristic of mature femininity (Deutsch, 1945; Balint, 1949; Antony and Benedeck, 1970; Winnicott, 1975), as an important developmental stage in an adult woman’s life (Chodorow, 1978; Bowlby, 1979), and in fact as the culmination of her psychosexual development (Breen, 1975; Gordon, 1978; Dally, 1978). Psychoanalytic theories of mothering gained wide currency in the 1940s and 1950s, as the social and economic upheavals following the end of the Second World War made it imperative for women to leave their war-work in factories and return home, leaving employment opportunities for men demobbed from the armed forces.

Mothering had now become, ideologically at least, a full-time occupation, and for some women this provided a source of immense satisfaction and respect: like

children, mothers too were now highly-valued and irreplaceable. For those women, however, who could not, or would not, live up to the ideal, it was difficult to avoid the opprobrium of society. Thus Badinter (1981:261) is able to write ‘Maternal anxiety and guilt have never been greater than in our century’ as each mother struggles to live up to impossible standards, knowing that if she fails a whole raft of professionals and lay-people stand ready to condemn her as evil, sick, or both. Psychology and psychiatry are particularly implicated in this modern evocation of the witch-trials of the Inquisition, whether we turn to Freudian notions of the ‘pathological mother’ (eg, Bender and Blau, 1937; Kaufman et al, 1954), or the ‘dysfunctional family’ (eg. Lustig, 1966; Machotka et al, 1967) or indeed Laing’s ‘schizophrenogenic’ family (Laing, 1971), always with the mother as key player. This tendency of overt mother-blaming reached its apotheosis in the 1960s and 1970s, coterminously with the rise of second-wave feminism, leading Friedan (1963:180) to exclaim in anguish:

‘Singled out for special attention was “the mother”, around whom an entire mystique was created. It was suddenly discovered that the mother could be blamed for almost everything. In every case history of a troubled child of an alcoholic, suicidal, schizophrenic, psychopathic, neurotic adult; impotent, homosexual male; frigid, promiscuous female; asthmatic, ulcerous, and otherwise disturbed American, could be found a mother. A frustrated, repressed, disturbed, martyred, never satisfied, unhappy woman. A demanding, nagging, shrewish wife. A rejecting, overprotecting, dominating mother.’

Alongside this vocabulary of maternal responsibility, failure, guilt and blame, mothers are likely also to experience other pressures militating against their undiluted pleasure in the maternal role. Feminist and other studies on mothering (see Rich, 1977; Boulton, 1983; Gordon, 1990) have highlighted how mothering, far from being the fulfilling pleasure which politicians and psychoanalysts envisage, is actually physically exhausting and tedious drudgery, and for many women is also socially isolating, boring, and likely to arouse feelings of inadequacy and depression (Brown and Harris, 1978; Boulton, 1983). For the majority of mothers, therefore, the cultural idealisation of motherhood is discordant with their lived reality of mothering (O'Connor, 1993). This may be partly because, whatever the idealisation laid on motherhood, the actual daily work of childcare itself has never been highly valued. As Boulton (1983:22) observes drily:

‘Motherhood may be necessary for women to establish their femininity, their respectability, and their maturity, but child care is a low-status occupation and women’s low self-esteem as mothers reflects this.’

Thus, alongside the contemporary cultural imperative of mother-love, requiring mothers to feel and express love for their children, is very often a pervasive sense of failure and guilt, linked to the gulf between the ideology of mothering and the everyday reality.

Ruddick (1990:31) has described this gulf:

‘An idealised figure of the Good Mother casts a long shadow on many actual mothers’ lives. ... Many mothers who live in the Good

Mother's shadow, knowing that they have been angry and resentful and remembering episodes of violence and neglect, come to feel that their lives are riddled with shameful secrets that even their closest friends can't share.'

Even without these 'shameful secrets' (which may perhaps constitute part of a woman's discreditable 'hidden account' of painful but almost unspoken experiences), mothers often have to contend with moving goal-posts - the changing nature of what constitutes a 'good mother' from decade to decade, whether to leave one's children with a nanny or raise them oneself, to cuddle and feed on demand or at regimented intervals, to breast-feed or bottle-feed, and so on. Holdsworth (1988:110) observes that, 'With such sharp U-turns [in fashions in mothering], it is hardly surprising that women are frequently riddled with guilt about the way they have brought up their children.'

Another reason for the pervasiveness of maternal guilt is the heavy moral weighting which is attached to motherhood, following from the highly-influential Evangelical view of the mother in the 1790s as the 'angel in the house' and the 'guardian of the home', and given added official weight subsequent to the Second Boer War (1889-1902), when public attention first focused on motherhood not merely as a personal moral duty but also as a national patriotic one (Hall, 1979). Thus there is a long history to the expectation that mothers will conduct themselves with propriety and raise their children within a moral framework.

Feminist-influenced analyses of mothering have also pointed to women's ambiguous relationship to power and responsibility under patriarchy, as a cause of the troubled state of motherhood (Dinnerstein, 1977; Rich, 1977; Rowbotham,

1989; Ruddick, 1990). Thus women are held ultimately to carry sole and total responsibility for their children (even where the father is also present), and yet at the same time are seldom able to assume the degree of personal power necessary to carry out this responsibility. As Rowbotham (1989:88) has described it, women have a ‘psychological image of motherhood as power and submission bound together.’

How mothers deal with such a demand for total and continual responsibility is by ‘coping’ on a day-to-day basis. This ideal of ‘unobtrusive competence’, equalling ‘self-effacement’ (Graham, 1982:103,105) leads us straight back once again to the enduring image, derived from Rousseau in the eighteenth century and the Evangelicals in the nineteenth century, of the self-sacrificing, patient mother, suffering like the Virgin Mary, devoting herself selflessly and uncomplainingly to her beloved children. Thus, even at the dawn of the new millennium, we inherit a concept of motherhood derived ultimately from the economic and social revolutions of the eighteenth century, with a strong emphasis on moral probity, mother-love, devotion, responsibility and, for many mothers, a sense of failure and guilt when such high normative standards cannot be attained.

Theorising childhood

Alongside the development of the modern concept of ‘mother’ in the eighteenth and nineteenth centuries, there was a corresponding development in the social construction of the category ‘child’. The rise of psychoanalysis in particular exerted a profound influence on the social construction of childhood, and this has been reinforced by the subsequent growth of psychology generally, and especially developmental and child psychology.

At the time that Freud developed his theories, childhood was constructed as a time of ‘innocence’, whether angelic or impish, left free to roam like Rousseau’s fictional Emile (1762) or, more commonly, physically chastised into instant obedience (see Miller, 1987). Implicit within this view, and theorised explicitly for the first time in the psychoanalytical writings of Sigmund Freud, is the conceptualisation of childhood as a series of stages to be successfully negotiated before full adulthood could be attained. This view of childhood as a linear progression in which identifiable developmental milestones are to be attained, was subsequently to inform the whole field of developmental psychology, underpinning the foundational work of child theorists from Montessori (1912, 1969) to Piaget (1955, 1959) and Erikson (1980).

As child psychology became a recognised specialism, the significance of the family environment began to appear increasingly important. This led in turn to a greater theoretical interest in families and parenting, and mothers as the lynchpin of the family and the key to child socialisation. Childhood, as with any other social construction, is in flux, and alters symbiotically with the construction of parenting (Jenks, 1982; James and Prout, 1990; Qvortrup, 1994). Thus, as childhood is constructed in each generation, so too is parenting (Ambert, 1994).

Sociological theories of childhood have developed as part of the sociology of the family and more general theories of socialisation, including the sociological processes of control, conformity and deviance (Jenks, 1982). To quote Jenks (1996:8-9):

‘in significant ways, the child, as conceptualized both within the spectrum of everyday attitudes and the professional discourses of

the social sciences, is employed, consciously though often unconsciously, as a device to propound versions of sociality and social cohesion. ... any view of the child reflects a preferred, but unexplored, model of the social order.'

From a sociological perspective, we can see how anxieties around social disorder and the desire for social cohesion and control can be articulated through discourses around childhood, particularly since, from a functionalist perspective, the child can be seen as representing the deviant and unsocialised Other. Real children are thus able in some sense to figure as ciphers, symbolising larger social discontents, fears and longings, our collective past and future, justifying Aries' (1962:395) observation that, 'Our world is obsessed by the physical, moral and sexual problems of children.'

But the child is not only the deviant and threateningly anarchic Other: the child is also the beloved and dependent Other, who indeed necessitates responses of containment, integration and social control, in order to maintain social stability, but within a framework of altruism on the part of the adult, especially the parent (Jenks, 1996).

As we have seen, children have become increasingly valued in their own right over the past two centuries (Badinter, 1981; Zelizer, 1985; Solinger, 1994). For Jenks (1996), there are two main dimensions to this contemporary valuing of children.

The first refers to the concept of 'futures'. As Giddens (1991) has explained, a key project of late/high modernity is the colonisation of the future, and for Jenks, one way in which this takes place is through children, with the 'promise' of childhood transformed into a form of human capital dedicated to futures: 'As children, and by

way of children, we have, through modernity, dreamt of futures' (Jenks, 1996:101).

However, Jenks also identifies a shift to the second dimension in contemporary valuing of children which is related not to the future but to the past. As modernity moves towards postmodernity, the child no longer represents hope for the future, but nostalgia for the past, becoming predominantly the locus of discourses concerning stability, integration, and the social bond. Where adult relationships no longer offer reliable love and trust, the adult-child bond can become a primary source of love and stability, and in situations of contested access - for example in divorce proceedings - we now witness increasingly acrimonious disputes, testifying, Jenks suggests, to the high levels of emotional investment represented by this adult-child bond. As Beck (1992:118) expresses it:

'The child is the source of the last remaining, irrevocable, unexchangeable primary relationship. Partners come and go. The child stays. Everything that is desired, but not realizable in the relationship, is directed to the child. With the increasing fragility of the relationship between the sexes the child acquires a monopoly on practical companionship, on an expression of feelings in a biological give and take that otherwise is becoming increasingly uncommon and doubtful. ... The child becomes the final alternative to loneliness that can be built up against the vanishing possibilities of love. It is the private type of re-enchantment, which arises with, and derives its meaning from, disenchantment.'

Although neither Beck nor Jenks refer to the gender of the adult in this adult-child bond, it seems likely that this description has more powerful resonance for women than men in contemporary society. While it is clear that the discourse of fatherhood is currently highly salient - as witnessed for example in a series of films, many of them Hollywood blockbusters, exploring father-son relationships, from Kramer vs Kramer (1979, director: Robert Benton) to Hook (1991, director: Steven Spielberg) and even The Full Monty (1997, director: Peter Cattaneo) - it is also clear that it is primarily women who would seem to be turning to relationships with children to satisfy their affective needs, in a society where the rhetoric and reality of gender relations are increasingly fractured and problematic.

What we have seen from the forgoing discussion on motherhood and childhood is that over the last two hundred years children have moved from the margins of adult social concern to centre-stage, from being regarded merely as a tedious nuisance to overtaking other adults as the primary love-object. Motherhood has equally altered, from being a significant but not all-encompassing role in women's lives to becoming their 'master status', the primary ground of their identity and hence a fertile source of anxiety and guilt, as the prescriptive yet competing characteristics of contemporary motherhood almost seem to have failure built into them, so that every mother seems at times to be caught between the impossibility of emulating the 'Good Mother' (Rich, 1977; Ruddick, 1990) and the terrifying threat of being castigated as the monstrous 'evil mother'.

At the micro level, therefore, individual women experience anxieties and tensions provoked by the prescriptive demands of the mothering role, while at the macro level, as Jenks argues, society invests in children both its hopes for the future and,

increasingly, its nostalgic longing for a safe and affectionate past. When we add to this a growing uncertainty about the role and function of fathers (and masculinity generally) in an age of high divorce-rates and fluid family forms (Giddens, 1992; Midgley and Clement, 1995; Economist, 1996a, 1996b; The Times, 1996), we have a powerful and profoundly anxiety-laden mix, and it is little wonder that the whole issue of the family, and children in particular, has become the locus of discourses eloquently articulating late-modern anxiety and despair.

When mothers fail

What happens when a mother does not behave as a mother 'ought'? As Jenks (1996:128), albeit in a context of speaking about children rather than mothers, describes the process, when the category becomes blurred, the conceptual boundaries which contain the 'mother' - through 'is' or 'ought' - are no longer defensible. This state of potentially dangerous confusion is untenable, and leads to a variety of strategies to contain and reduce the confusion. One strategy is 'conceptual eviction' - individual women are removed from the category 'mother', in order to restore the moral order and re-establish the traditional ideological discourse of motherhood. Eviction takes place through the use of 'images of radical alterity': these images, by setting up new, deviant, categories, are employed to evict persons from their previous category. Jenks identifies three images of alterity (among many other possible images). These include the 'inherently evil' creature, secondly the 'depraved composite' creature (in his example the 'adult-child'), and thirdly the 'corrupted or victimised' creature, which may stand for the corruption and dissolution of society itself.

These three transgressive images constitute a powerful and volatile ambiguity in public discourse, and can be understood as developed in response to a felt threat to the cosmology posed by ‘fractures’ or anomalies in the normative category (Douglas, 1966). More than this, Jenks finds that the anomalous case is essentialised as inherently evil or pathological, thus providing an explanation for why these anomalous cases exist - normal individuals within the category *could not* have done these acts; only essentially evil/sick individuals could have done it. Anomalies, of course, serve the function of delineating and confirming boundaries (Garfinkel, 1956). By removing the anomalies from the category, the public re-affirms its commitment to a shared social order: ‘the system of classification stays intact by resisting the “defilement” of the abhorrent case.’ (Jenks, 1996:129).

As briefly discussed in the introductory chapter, using the example of the media treatment of the heroin-dependent mother of a murdered five-year-old, Dillon Hull, substance-using mothers are vulnerable to being assigned by the media and others to this category of inherently evil or pathological mother. This category of ‘evil mother’, as a category of ‘radical alterity’, stands in polar opposition to the category of ‘normative mother’ or ‘Good Mother’. This study interrogates such opposed categories through employing a third category - that of ‘problematic mother’ - which side-steps binary opposition and permits categorical and conceptual ambiguity and tension to remain.

‘Evil mothers’ have always existed in fact and legend (often portrayed in children’s stories as the ‘evil step-mother’), but first began to enter social policy in the nineteenth century when concern over ‘unfit parents’ shifted its emphasis from fathers to mothers, perhaps as a response to rising expectations of motherhood.

The nineteenth century saw the first major evidence of popular and state concern over family-life generally, and the existence of child crime, as Victorian social commentators such as Henry Mayhew drew attention to ‘vast shoals’ of delinquent urban children ‘trained from their infancy in the bosom of crime’ (1862, re-published 1950:133-4). The beginning of State intervention in this issue can be traced to 1889, with the establishment of the National Society for the Prevention of Cruelty to Children and the 1889 Poor Law (Children) Act, giving Boards of Guardians authority to assume parental rights over children in care. The 1904 Prevention of Cruelty to Children Act transferred this responsibility to local authorities instead, giving them, for the first time, coercive powers of child removal from ‘unfit parents’. The emphasis was on the removal and rescue of children, who were felt to benefit from the change of living-environment. However, the wide-scale evacuation of children during the Second World War (1935-49) and subsequent concerns over separation and maternal deprivation shifted policy towards encouraging families to stay together. The Acts relating to children and young people passed in 1948, 1963 and 1969 all affirmed this view of the family as essentially benign, and 19th century concerns with cruelty and neglect within the family were forgotten (Parton, 1991). Meanwhile, however, continuing concerns over juvenile delinquency continued to fluctuate between responses of welfarism and punishment, where children were alternately viewed as largely innocent victims of dysfunctional families - thus requiring a welfarist response of rescue and help - or else as young criminals requiring a response of punishment and custodial confinement. These competing ideologies have shaped the response to the problem of juvenile delinquency, from the Reformatory schools of the 1850s and then the

more overtly punitive borstals inaugurated in 1908, up to the Conservative Government response to a wave of joy-riding incidents in 1991, in which the Criminal Justice Act 1991 placed great emphasis on enforcing parental responsibility for children's behaviour, and also stressed that the response should be community-based rather than custodial, while at the same time establishing a new offence of Aggravated Vehicle Taking which allowed courts to sentence juveniles for up to five years for joy-riding (McLaughlin and Muncie, 1993).

Within these contradictory responses, the role of the family is pivotal. As McLaughlin and Muncie (1993:155) argue, throughout the history of juvenile justice: 'the role of the family has been a paradoxical one. Sometimes the family has been seen as a contributing factor to delinquent behaviour; at other times it has been seen as offering the best potential for curbing it.' Thus the notion of the family as a private arena is qualified by the perceived necessity for the state to intervene in and regulate family life when things go wrong. Non-compliance with notions derived from Victorian domestic ideology initially prompted state intervention in mainly working-class family lifestyles and childrearing practices. Delinquency, as McLaughlin and Muncie (1993) make clear, does not simply refer to criminal behaviour but to a lack of the inculcation, by the family and especially the mother, of 'proper' moral values and habits. Thus the State response to juvenile delinquency has always struggled both to punish and discourage the 'depraved' while protecting and caring for the 'deprived', to remove parental rights from irresponsible and delinquent families, while encouraging parental responsibility among the majority. As McLaughlin and Muncie (1993:160, emphasis in original) discuss, the legacy of Victorian notions of the 'depraved'

and/or 'deprived' child has been that, by 'defining delinquency as being caused by a lack of *moral* care ... the issue not only concerns identified offenders, but also working class childrearing practices in general.'

State responses to such problematic behaviour are closely connected to concerns, expressed since the nineteenth century, over the reproduction of a criminal underclass via intergenerationally transmitted disadvantage, conceptualised as a 'cycle of deprivation'. These concerns became particularly cogent in the 1970s, when the then Secretary of State for Social Services, Sir Keith Joseph, posed the question, in 1972: 'why is it that, in spite of long periods of full employment and relative prosperity and the improvement in community services since the Second World War, deprivation and problems of maladjustment so conspicuously persist?' (quoted in Rutter and Madge, 1976:3). In this speech Sir Keith Joseph explicitly linked together his suggestion of a cycle of transmitted deprivation to parenting, stating 'It seems perhaps that much deprivation and maladjustment persist from generation to generation through what I have called a "cycle of deprivation"'. People who were themselves deprived in one or more ways in childhood become in turn the parents of another generation of deprived children.'

To explore this cycle of deprivation, a Working Party on Transmitted Deprivation, set up in 1972, commissioned Michael Rutter and Nicola Madge to undertake a literature review on British and American research on deprivation. Their conclusion, after a comprehensive review, was that, overall, 'there are moderate continuities over two generations' (Rutter and Madge, 1976:303). Continuities were found, but these were often linked to broad structural factors such as geographical areas of deprivation. With regard to parenting *per se*, they concluded from the evidence

that ‘intergenerational continuity is least for aspects of parenting within the normal range and greatest with seriously abnormal parenting’ such as child-battering (Rutter and Madge, 1976:237). From the studies, evidence seemed to suggest that parents exposed to cruelty or neglect as children were more likely than the general population to physically batter their own children, but that generally research was lacking to examine this in depth. No clear distinction was made between fathers and mothers, although the focus appeared, in these studies, to be more on fathers.

In conjunction with the overview of research by Rutter and Madge, some 37 different studies were also conducted, producing in all twenty books on the topic of the ‘cycle of deprivation’ (Walker, 1990: 52). One of the main findings throughout this research programme was that there was very little evidence of a simple continuity of social problems between generations. As the final report on this research programme expressed it, ‘continuities are by no means inevitable and there is no general sense in which “like begets like”’ (Brown and Madge, 1982:143). Similar findings also emerged from the research programmes of the American War on Poverty in the late 1960s. Notwithstanding such findings, the concept remained of a segment of the working class in which was concentrated certain forms of anti-social behaviour and which reproduced this behaviour through illegitimacy, unemployment and crime. Gradually this segment came to be known as the ‘underclass’ (Morris, 1994).

The notion of the ‘underclass’ is a highly salient one in any discussion of problematic mothering, particularly where the use of illicit drugs is concerned. The existence of an ‘underclass’ at all is controversial (Field, 1989), but since the time of Henry Mayhew a particular section of the working-class has been singled out for

note, and termed the ‘undeserving’ or ‘dishonest poor’. This view of the working-class as divided into two segments has recently received widespread interest through the writings of Charles Murray (1984, 1990), a North American thinker considered the ‘guru who inspired Back to Basics’ (Guardian, 1994a:29). Murray distinguishes a class separate from ‘the poor’, which are characterised by ‘their undesirable behaviour, including drug-taking, crime, illegitimacy, failure to hold down a job, truancy from school and casual violence.’ (Foreword by David Green in Murray, 1990). As Murray (1990:1) describes it:

‘I grew up knowing what the underclass was; we just didn’t call it that in those days ... I was taught by my middle-class parents that there were two kinds of poor people. One class ... simply lived with low incomes ... Then there was another set of poor people, just a handful of them. These poor people didn’t lack just money. They were defined by their behaviour. Their homes were littered and unkempt. The men in the family were unable to hold down a job for more than a few weeks at a time. Drunkenness was common. The children grew up ill-schooled and ill-behaved and contributed a disproportionate share of the local juvenile delinquents.’

Murray (1990:2) notes the spread of ‘Drugs, crime, illegitimacy, homelessness, drop-out from the job market, drop-out from school, casual violence’ and consequent deterioration of whole communities in the 1960s and 1970s. Increased illicit drug-use is thus seen as part of the motor driving the development of the underclass. In both North America and Britain, heroin-use has been rising to unprecedented levels since the mid-1980s (Shapiro, 1996), and Murray,

investigating the situation in Britain in 1989, characterises himself (1990:3) as ‘a visitor from a plague area come to see whether the disease is spreading’, asking rhetorically of the underclass ‘how contagious is this disease? Is it going to spread indefinitely, or will it be self-containing?’ (1990:23).

Fear of the urban underclass, both in North America and Britain, is linked symbiotically to fear, not only of illicit drug-use, but also of problematic mothers: single mothers, teenage mothers, unsocialised and delinquent mothers. A series of laws, from the Poor Law Act of 1576 and the 1601 Elizabethan Poor Law, through the 1662 Act of Settlement, the 1733 Bastardy Act, up to the 1834 New Poor Law, overtly stigmatised unmarried and deserted mothers in order to deter others from financial reliance on the parish (Page, 1984). In the nineteenth century, financial stigma remained but was additionally reinforced by the view, developed through the new discipline of psychiatry, that unmarried mothers were psychiatrically impaired and, under the 1913 Mental Deficiency Act, were liable to compulsory detention. The notion of single mothers as psychiatrically ill continued into the 1950s and 1960s (Page, 1984), but has recently been replaced by an arguably more sinister view of them as indifferently or selfishly undermining the entire fabric of society (Laws, 1996; Bortolaia Silva, 1996). The Conservative Government (1979-1997), in its attack on single mothers, both caught and reinforced a popular mood in Britain and North America in the 1990s, a time when the ‘ultimate symbol of the sponger’ had become ‘a teenage mother, trapped in a cycle of dependency’, arousing not sympathy but fear that she, ‘a poorly socialised teenage mother’, would produce ‘a poorly socialised child - a burden to the taxpayers, a menace to society.’ (Guardian, 1994b:14).

These fears soon led to calls for separation of mother and child (for example, see Spectator editorial, 1993, calling for the Government to ‘put down the burden of the self-indulgence of unmarried mothers and their men’), whether engineered through cuts in welfare payments and the reintroduction of orphanages (as proposed by Newt Gingrich in his Contract with America in 1994), or changes in adoption law, a change ironically summarised (Guardian, 1996:5) as one designed to take ‘the children of the undeserving poor and give them to the deserving middle classes, and all will be well.’ Recent proposed changes in adoption law, inherited from the previous Conservative Government and supported by the current Labour Government, do indeed seem to be aimed at facilitating legally-enforced adoption of children from parents, very often lone mothers, perceived as inadequate. Thus the Sunday Telegraph (1996:25) observed baldly that ‘the compulsory adoption of children ... would be permitted’, and a headline in The Times (March 29th, 1996: 4) states: ‘Government acts to cut red tape holding back adoption’, and goes on to explain that in the draft Bill:

‘natural parents will have their rights reduced. Previously the courts could force a mother to give up a child for adoption only if they could prove she was acting unreasonably. Now they need only decide it is in the child’s welfare to make her hand it over. Social workers will be encouraged to use adoption rather than foster parents or children’s homes. A struggling mother who keeps putting her children into care then taking them back when she can cope again could find the council trying to have them adopted.’

More recently (Guardian, January 26th, 1999:3), there have been calls by the Home Secretary, Jack Straw, to encourage adoption, particularly for teenage mothers, with Straw stating, 'It is still a sad fact that many suitable [adoptive] couples have been on waiting lists far too long, while children have remained in care ... It is better if these adoptions are done voluntarily than if the children are later taken into care.' This view of the positive benefits of the voluntary or involuntary separation of the child from its family - in this case via adoption - fits in with the general welfarist project, discussed earlier, to rescue and rehabilitate 'deprived' children from inadequate families. In the earlier discussion, the emphasis was on the child as delinquent, here it is on the mother as delinquent, but the solution to the problem in both cases is seen as the same: rescue of the child from the family home. Again, this concept of the state as providing rescue and protection for children from damaging family backgrounds ties in with yet another discourse on parenting, concerned with 'baby battering', 'child abuse' and, more recently, 'child protection' (Parton, 1991). This discourse is a new twist in the continuing state concern with juvenile delinquency, the 'cycle of deprivation' and a view of the 'underclass' as essentially composed of inadequate and damaging parents, but also opens out the general purview and jurisdiction of the state into parenting across society, including middle-class parenting behaviours.

'Battered child syndrome' (known in Britain as 'battered baby syndrome') was first identified by Dr Henry Kempe in the early 1960s, following on from the work in the 1940s of a North American radiologist, Dr John Caffey, on the existence of a recognisable pattern of limb-fractures linked to subdural haematomas in children, a pattern linked to parental indifference in later studies by Drs Wooley and Evans in

the 1950s (Parton, 1985). Physical abuse of children by adult carers thus came to public notice through a medical model of a 'syndrome' requiring diagnosis and treatment. It contrasted starkly with the prevailing post-war social work view of families as essentially benign forces in children's lives, where what Sir Keith Joseph had termed 'maladjustment' in families was linked conceptually to 'deprivation' rather than - as in the nineteenth century - to depravity. These two opposing views, of 'baby battering' contrasted with essential benignity of parents, came together in an explosive mix in 1973 with the high-profile media coverage of the death of Maria Colwell at the hands of her step-father and with the apparent collusion of her mother. The subsequent moral panic (Parton, 1991:10) led to a series of public enquiries over the deaths of small children within their families, and to a fundamental re-think of social work policy which has continued up to the present, evidenced in a new policy emphasis first on 'child abuse', and then on 'child protection' and the legal requirement to protect children from 'significant harm' enshrined in the 1989 Children Act (Adcock et al, 1991). It is arguably this view of children as requiring rescue and protection from abusive parents which may underlie current attitudes to substance-using and other problematic mothers.

Jenks (1996) has identified two competing views struggling for primacy in social understandings of childhood. These are the Dionysian vision of children and the Apollonian vision (which would seem to be linked to the notion, discussed earlier, of the child as both the anarchic Other requiring discipline and the dependent Other requiring care). In the Dionysian view, the child is essentially sinful and unsocialised, requiring control, punishment and heavy-handed discipline. The Apollonian view, by contrast, sees children as essentially innocent, wise, attractive,

loveable and immeasurably precious, requiring and deserving state care and protection. It is this latter, Apollonian, vision of children which 'lies at the heart of attempts to protect the unborn ... [and] to criminalize certain "unfit" states of motherhood such as drug-addiction or HIV infection.' (Jenks, 1996:73).

Linking this back to the earlier discussions on motherhood and children, it is clear that the Dionysian view of children was the prevailing view prior to Rousseau, and that subsequently it has been the Apollonian view of children which has most strongly informed debates around parenting and the role of mothers as nurturers and protectors. Nevertheless, the earlier, Dionysian, image retains power, and it is this image which Murray (quoted in the Guardian, 1994a:29) was invoking when he deplored what he regards as the inadequate raising of boys by single mothers: 'each generation is invaded by a horde of barbarians - our kids. Without socialisation, crime is going to be astronomical'.

Thus both the Dionysian vision of children as chiefly requiring discipline and socialisation, and the Apollonian vision of children as chiefly requiring nurturance and protection may be used to problematise and indeed criminalise certain mothers, and to justify surveillance, intervention and even enforced separation of child and mother.

Thus, when a mother fails in her maternal responsibility, for example by allowing her child to be exposed to danger through her own substance-use, it is clear that there is already a powerful group of discourses in place within which to understand and respond to her failure. She herself may well be exposed to the stigma of eviction from the category of 'normative mother' into the radical alterity of the 'evil mother' category. Both the 'delinquency' discourse of rescuing a (Dionysian)

child from a 'depraved' family, and the 'cycle of deprivation' discourse of rehabilitating an (Apollonian) child from a 'deprived' family, may come into play. So too may the more recent discourse of the under-socialised 'underclass' mother, again justifying a rhetoric of 'child protection' and thus the separation of mother and child. All of these discourses take into account the increasing social valuation of the child, who now represents, as Jenks (1996) has argued, both the hope for the future and nostalgia for the past. However, what such discourses may omit is the personal valuation of the child by the mother who, as Beck (1992:118) suggested, may view her child as 'the source of the last remaining, irrevocable, unexchangeable primary relationship ... the final alternative to loneliness that can be built up against the vanishing possibilities of love.' (What such discourses also routinely omit is any emphasis on the role of the father, who is very likely to 'disappear' from any child protection investigations (Milner, 1993) while the full weight of scrutiny and responsibility remains squarely on the mother (O'Hagan and Dillenburg, 1995).)

The final section of this chapter now looks at what currently happens in practice to substance-using mothers who are seen to have failed in their responsibility towards their children.

Social policy responses to substance-using mothers

As theorists of family law have argued (see Masson, 1995:208), it is not only 'who they are' but 'what they do' which defines a person as a parent, and which may legally justify disallowal of the status of parent. Thus, in the United States, taking illegal psychoactive substances in pregnancy, particularly crack-cocaine, has been used as legal evidence of child abuse, justifying imprisonment of the mother and

involuntary removal of her child for fostering and possible later adoption.

Legislation allowing this is now enacted in most states in North America, following the initial passing of the 'Minnesota crack-baby law' in 1989 (Fortney, 1990; Nyhus Johnson, 1990). Such a response to problematic motherhood is mediated by attitudes that permit, for example, a judge to enquire rhetorically, "Obviously you want to protect society from a dangerous armed robber who is going to rob again. Is not an unborn baby equally entitled to protection from a mother who cannot stay away from cocaine?" (quoted in Lusane, 1992:58).

This rhetoric of protection of the child and punishment of the mother has so far been far more muted in Britain, with only one notable case to date, the 'Berkshire case' in 1986, in which parents were taken to court for child abuse, following the use of heroin during pregnancy (Levin, 1987; Perry, 1987). Thus, while the North American sense of babies and children needing protection from their substance-using parents finds an echo in British social policy, the response to date has clearly not been one of blatant punishment and denigration as in the United States. Rather, it would seem that what has evolved has been part of a 'softer' model of family law and social policy around childcare generally, reliant less on the harsh application of law but the more insidious technique of surveillance to compel adherence to certain norms of behaviour (Hutter and Williams, 1981; Smart, 1989, 1991; Smart and Sevenhuijsen, 1989).

This gentler and more relaxed British approach to substance-using mothers may now, however, be in the process of change, mediated through the increasing, or increasingly vocal, involvement of grandparents, particularly grandmothers. Parents of substance-using mothers (but not, apparently, substance-using fathers) may take

over the role of primary carers of their grandchildren when their daughter is perceived as failing in her mothering role, or when she herself asks for help. This pattern of help by grandmothers is of course not restricted to substance-using women, but has been frequently noted in the sociological literature on families (Young and Wilmott, 1962; Warnes, 1986; Devine, 1989; Finch, 1989; Ribbens, 1994). If mothers cannot provide full-time care and fathers are not available, grandmothers are widely regarded as the most suitable substitute carers (Daniels, 1980; Brannen and Moss, 1988; Ribbens, 1994). Although grandmothers are frequently seen as the most important resource with whom to share childrearing concerns (Ribbens, 1994), tension often exists in this relationship (Blaxter and Paterson, 1982; Cunningham-Burley, 1985, 1986), related to the issue of maternal authority (Ribbens, 1994).

In relation to substance-using mothers, this pattern was noted by Rosenbaum in 1981 who stated (1981a:98): 'The woman often has family members who are willing to take the children ... I found this to be the case most often among black women, who had mothers, aunts, and sisters who were available. The arrangement was seen as temporary and did not have the impact and guilt that characterizes losing children to institutions.'

There are similar findings from other studies (Lawson and Wilson, 1980; Colten, 1982; Tucker, 1979, 1982; Kaufman, 1985; Taylor, 1993). Along with Colten (1982) and Tucker (1979, 1982), Taylor (1993:115) found, in her sample of predominantly white Glaswegian women, that this option could have drawbacks, however:

‘Whilst the existence of a social support network in the form of their families was obviously present for [some] women, such support was often offered for the sake of the children, and it was their interests that family members had at heart rather than those of the women.’

Representations of this phenomenon in the media have recently moved from an emphasis on the tragic - with headlines such as ‘She’s a junkie but she’s still my little girl’ (Best, 1994) - to a more overtly hostile stance towards the substance-using mother, in which there is clear evidence that she is, in Jenks’ (1996) terms, being ‘evicted’ from the category of ‘mother’ into a ‘radical image of alterity’, that of ‘evil mother’. Thus the Daily Mail on May 7th, 1998, had a front-page article headlined ‘Why I sent my daughter to prison’, in which the mother observed of her heroin-dependent daughter,

‘I still love her but I have no regrets. She deserves it. If anything we wish the sentence was a little bit longer. My daughter isn’t a fit mother. She placed those children at risk. They could have swallowed the drugs and died. We just had to get them out of that house.’

In October 1998, a series of three incidents involving schoolchildren in possession of drugs strengthened the concern with ‘the plight of addicts’ children’ (Guardian, 1998a:10). These incidents - of a young boy with a large quantity of cannabis at an infant school in Surrey; a boy of eleven found with a large supply of heroin in a school in Glasgow; and a seven-year-old boy who took his mother’s heroin into school in Stirling - were linked in media comments to the death in January 1998 of

a thirteen-year-old boy from a heroin overdose. The seven-year-old boy in particular, who had apparently taken the heroin into school in a bid to get help for his mother, was viewed as evidence of how ‘innocent people were being hurt by heroin’ (Guardian, 1998b:2). A subsequent article, headlined ‘Anguish of grandparents who live in junkie hell’ (Guardian, 1998a:10) included comments from grandparents such as ‘the worst bit is yet to come. Joe [her three-year-old grandson currently living with her] is always asking where his mummy is and one day I’m going to have to tell him that she prefers heroin to him. I wish she was dead, at least then I could tell him she was with Jesus.’ Another grandmother stated, ‘If you have a junkie child there comes a point where you have to give up on them, but you can’t give up on your grandchildren.’ A third grandmother described,

‘I wish she was dead, God forgive me, and I wish someone was looking after Sharon [her granddaughter] properly. ... I lie awake every night wondering what’s happening to Sharon. She used to be a lovely wee girl. I don’t care what happens to my daughter, but Sharon is innocent and I have to save her from my daughter.’

In the media representations of this phenomenon of grandparents caring for their drug-dependent offspring’s children, we may be seeing the beginning of a new moral panic, with the ‘drug-using mother’ taking over from the ‘single mother’ as the latest ‘folk devil’ (Cohen, 1972). A moral panic of this nature would have severe implications for substance-using mothers generally, and this will be explored in more depth in the final chapter, once we have mapped out the experiences, attitudes and perceptions of the substance-using mothers investigated in this study.

Chapter Five: **'Wildly Unmothered' - The Respondents' Own Experiences As Children**

Introduction

Chapters One and Two have laid out the aims and methods of the research, and Chapters Three and Four have provided background on women's substance-use and on mothering, against which the following chapters are now able to foreground the women's own experiences as analysed from the interview data. Although the women's experiences of being mothered as children was not originally envisaged as a main focus of the research, analysis of interview transcripts revealed interesting patterns in their experiences of upbringing and their own subsequent attitude to mothering.

Despite the fact that this analysis is only derived from information volunteered by the women during interviews (since it was not until the research was almost completed that the respondents' backgrounds began to be recognised as an appropriate focus of research) and thus the data from which the analysis is derived are therefore limited and partial and likely to be an *under-representation* of the true picture, what is significant are the broad patterns which are nevertheless discernible from the respondents' remarks. These are patterns of having been brought up in emotionally difficult and damaging homes and of having been 'looked after' by social services, and their subsequent attitudes towards their own mothers as role-models; their attitudes to trust and closeness which were affected by issues of gender; and their experiences of childhood sexual and physical abuse revealed during the interviews. Running through their narratives are issues which are still

highly salient in the respondents' lives today: their lack of family support; their sense of uncertainty about 'good mothering'; their difficulties in trusting and relating to other women; and their ongoing troubled mother-daughter relationship with their own mothers.

None of these issues are exclusive to substance-using mothers alone, but can be seen as an invisible thread tying together the experiences of many women under patriarchy, explored perhaps most accurately and cogently by Rich in the 1970s. She was the first to make explicit what had otherwise only been hinted at by other feminist writers - the anger between mother and daughter. As she writes (1977:224-5):

'There was, is, in most of us, a girl-child still longing for a woman's nurture, tenderness, and approval, a woman's power exerted in our defense ... But if a mother had deserted us, by dying, or putting us up for adoption, or because life had driven her into alcohol or drugs, chronic depression or madness, if she had been forced to leave us with indifferent, uncaring strangers ... the child in us, the small female who grew up in a male-controlled world, still feels, at moments, wildly unmothered.'

If we look first at what respondents said about their childhood generally, we find that they were more likely to volunteer negative experiences than positive ones. Thus, out of the sample of forty-eight women, of those who volunteered information relating to their childhood, there were six volunteered remarks that parents were strict; eight that they were unloving; six that the respondents felt they were treated differently or felt different as children from their siblings; and eight

that they were the 'black sheep' of their family. No respondents referred to feeling consistently and unproblematically loved and valued by their mother, although they did mention incidents of being loved by them, which will be discussed. In contrast to this complete absence, four respondents appeared to have felt consistently loved and valued by their fathers.

There appears to be anecdotal evidence from workers in the field that many drug-users have been 'looked after' or put 'in care' as children, although it is difficult to find statistical evidence to support this claim. Among this sample of 48 respondents, twelve (25%) mentioned having been in care at some point in their childhood. If only the illicit drug users are considered, then of the sample of 37, eleven (30%) mentioned having been in care. Only one non-illicit substance-user, Amanda, who uses alcohol, mentioned having been in care during the interview (ie one out of the sample of eleven). There was no specific question in the interview schedules on this, so it may well be that other respondents had experience of being in care but it was not mentioned.²

Thus, of this sample, at least a third of the illicit drug using respondents had been in care as children. This finding seems to support the anecdotal evidence from the field that a high proportion of drug-users have previously experienced being in the care of the local authority.

The context of having been accepted into local authority care obviously presumes that the respondents' experiences of being parented was inadequate prior to the Social Services' involvement. However, in addition to these twelve respondents,

² It should also be noted that the interview with Amanda was largely unstructured and she was not asked about any other drug-use specifically - apart from her alcohol-use - during the interview.

others who were not taken 'into care' nevertheless also experienced very painful and damaging upbringings. Of the eleven respondents (23%) who mentioned having been sexually abused as a child, not one of these had been taken into care. (For a twelfth respondent, it may well have been concerns over sexual abuse which resulted in her being taken into care, but this was not clear from the interview.)

The issue of childhood sexual abuse is discussed in more depth later in this section.

In addition to these problems, two respondents talked about having been adopted as children, and the disturbing impact which their subsequent discovery of this had on them. One respondent 'was told in anger' of her adopted status as a young adult, and the discovery destroyed her relationship with her family and appears to have been a motivating factor in her first use of drugs. The other respondent had a strong relationship with her adoptive parents and her adopted status appears to be less likely to have affected her entry into drug-use.

For ten of the respondents (21%), at least one parent (in nine cases the father) had an alcohol problem; for a further two of the respondents the father was heroin-dependent and the mother of one respondent was tranquilliser-dependent. (In addition, the parents of one respondent were large-scale cannabis dealers). Thus altogether at least thirteen respondents (27%) had at least one parent heavily involved in substance-use. For seven of the respondents (15%), siblings also used opiates or other illicit drugs (other than cannabis).

A few of the respondents also mentioned domestic violence in their childhood, and this will be discussed in the following section.

Thus, while the concept of a 'happy' or 'unhappy' childhood is subjectively-based and difficult to quantify, it seems clear that if we combine the variables of having been in care, having been sexually abused, or feeling unloved, then at least 19 of the 37 illicit drug users (51%), and 22 of the total sample of 48 women respondents (46%) had at least one of these experiences, and thus could reasonably be said to have had an unhappy childhood for at least a part of the time.

Respondents' own mothers as role-models

The long-term effect of their upbringing showed itself in the way in which respondents talked about their parents, especially mothers, as role-models (or, more exactly, contra role-models) for their own parenting behaviour. With many of the respondents, the subject of their parents and the impact of their parents' example on their own mothering was not explored, but this topic was discussed by ten of the women, all but one illicit drug users. Although other respondents made reference to their parents, only these ten explicitly linked their childhood experiences with their current mothering practice, making comments such as 'I ain't going to do to [my daughter] what I had done to me.' (00E:9) ³

For example, Annie could recall only one incident of open affection from her mother: 'Only once I can remember I had an ear-ache once when I was a kid and I remember getting into her bed. I remember her cuddling me then and stroking me ear. That's the only time I can ever remember her like that.' (003b:3).

³ The six respondents from the MA sample are coded alphabetically 00A to 00F; the forty-two respondents from the doctoral sample are coded 001 to 042. Their partners or relatives, where they need to be differentiated, are designated by the use of an initial '1' instead of an initial '0', for example, Carrie is designated 024 and her partner Matthew is designated 124.

Annie had deliberately chosen to show her affection more openly to her children, although this was hard for her to do:

‘I think that’s probably why I don’t put me arm around [child] because me mum never done it to me. -- I think that’s why I can’t give her a love and that. I mean every night before [child] goes to bed she’ll come and give me a kiss. At one time I used to cringe. I used to think, “Don’t fucking kiss me. Just don’t do it.” Now I don’t, you know, I don’t feel that bad now, but I do still find it hard to go up and give her a love. -- I knew that it was wrong. I knew that it weren’t right to feel like that about your family, like, and not being able to put your arm round them and that. It’s not fucking right, is it. I just - and I just thought I don’t want to end up like my mum. -- She’s ever such a hard woman.’ (003c:11)

Carrie and her partner Matthew appeared to be one of the few examples in the sample of a close-knit, supportive family. When asked where she had developed her ideas on family-life, she replied, ‘It’s just what I’ve done myself because I’ve made sure, I’ve thought thick and hard that what I went through they’re certainly not going to go through. *Certainly* not!’ (024a:5). Carrie had had a very disrupted and dysfunctional family life, where, for example, both parents drank heavily and two siblings were injecting heroin in front of her when she was ten years old.

Deborah had given this aspect of her life a great deal of thought. Like Annie, she can only recall one incident where her mother showed her affection, when she was aged three. ‘The only close moment ever with my mum. -- [when her grandmother died] we both sat on the sofa -- and cried and she cuddled me. And I can actually

remember that time, like.' (012a:6). She shares the fears of professionals that she may not be able to bring up her child lovingly, and was distraught when her probation officer asked her (012b:5):

“Can you possibly conceive to love that child when you never got loved when you were a child? So I think the truth of the matter is you don't know how to love her because you don't know what love is.” And I was sat there fucking convinced - I was in prison - and broke me heart for weeks after, had to have counselling and everything. Fucking suicidal. Cut me wrists up and everything in the prison. Because I was sat there convinced that I didn't know how to love her. That I couldn't be a mother because I didn't know how to give her love.'

Her mother was extremely violent throughout her childhood and Deborah dislikes even shouting at her four-year-old now:

'sometimes I hate myself. This has been getting me down an awful lot lately. When I have shouted at Agnes, at the time I've thought well, yeah, she's doing something wrong. But then sometimes I think I'm handling it wrong, and should I shout or should I try and talk to her instead. And when I'm actually there shouting at her it's like I feel like me mum. It's like - that is all that I know how to deal with that kind of situation. Because that is all I've seen. That is how my mum used to deal with it. So that's all I know. -- I smacked her on the leg once and that was ages ago. She kicked a cup of hot chocolate straight across the room all over the settee and all over

the wall. So I come in and smacked her and I walked straight out the room and went to the kitchen and broke me fucking heart. I nearly collapsed with crying because I felt that bad. -- it makes me feel like my mum. And I fucking hate that bit. I hate it. You know, I wish she'd never existed because that is the only fucking thing she's passed down to me is that temper.' (012b:17)

For Margaret, 'I was very close to my father. A lot closer to my father than I was with my mother. I don't have any recollection of my mother holding me, hugging me, kissing me. I got all that from my father. -- I had a very very strict upbringing - - If I said anything wrong or swore, my mother used to wash my mouth out with soap. -- I feel being cruel to [child] just by shouting at her.' (005a:7; 005b:2).

For Patty, again, 'The first time my mum ever cuddled me was when she was dying. When she was leaving me.' (024a:33). Like Annie, Patty and her partner made a conscious decision to be demonstrative with their baby, 'Because we didn't want - we don't, I feel as though - I didn't like the way we got brought up and that. And I want to change it. So they have a better life than we did. And be protected a bit more.' Patty, however, believes 'She didn't think about herself at all. -- She'd do anything for us. -- She was a really good mother. She just wasn't close in that sense. Closeness. She wouldn't cuddle you or whatever.' (024a:33). It is interesting that Patty's partner, Sean, had very similar experiences of distant parents. As he said: 'The first time I got a cuddle off my mum and dad was when I stabbed a guy. -- It was the first time I'd ever actually, you know, got comfort off my mum and dad, saying "It's alright, son". I was 21 then.' (ibid.)

Sandra's perception that her alcohol-use was turning her into her own, alcohol-using, mother was a trigger for her to seek help with her drinking: 'I didn't want to become my own mother. -- I felt that if I carried on doing what I was doing then I would be pushing away my children and my husband in the same way as what my mother has always pushed me away. -- I suppose that all stems from the way I felt about my own childhood.' (029:14)

Alienation from mothers and other women

It is noteworthy that, although it may have been the case, no respondent in any interview referred to her mother as a strongly positive role-model. Where closeness was expressed, it was likely to be towards the father rather than the mother. This may possibly link in with the fact that at least two of the respondents recalled that they were known as 'tomboys' in childhood, and a number of them explicitly stated that they preferred the friendship of men to women, and perhaps did not feel as comfortable with women. For example, Annie noted that 'I prefer the men than women' and, as she expressed it, although she knew drug-using men she wouldn't trust, she also knew some she would trust, whereas 'There's not one girl or lady who I know who uses drugs who I like or who I would have in my [house] - who I would trust.' (003e:7)

Beverley also found it hard to trust women, which she explicitly attributed to her relationship with her mother. She said, for example, that 'I trust more men than I do women. Dunno why. Maybe because of my mum.' (001b:1).

Stella commented that 'girls seem to look at me some - I don't get on with girls for some reason. I get on - put ten men in here and I could sit there and talk to each

one of them and feel really comfortable. I'm not worried about what I say. But if there was ten women I'd have trouble because ever since I was little I was a tomboy as well. And, like, I relate to men. And girls, right - I'm a really sound person as well - but girls for some reason feel threatened. They feel threatened towards me. I think it's because they think I'm boisterous and loud and take drugs.' (004b:11)

None of the respondents expressed the opposite view during the interviews - that they preferred women to men - and very few of the respondents (including the two gay respondents) mentioned having any close female friends, only Alison and Bernice being the exceptions in this.

Alongside this finding of a tendency to identify more closely with men, there is the finding, as mentioned earlier, that at least eleven of the forty-eight respondents (23%) had been sexually abused as children. This two findings may not be unrelated in some cases, as Bollerud (1990:85) has observed: 'Female victims of abuse tend to devalue themselves and other women. They are often alienated or estranged from same-sex peers. Paradoxically, they view men as sources of security and nurturance and see women as judgemental and untrustworthy.'

In my analysis, this alienation from other women does not need to be seen as a correlate of previous sexual abuse but can be understood within the more general framework of patriarchal 'relations of ruling' (Smith, 1990) where women are generally devalued in relation to the valuing of men. Thus one feminist psychoanalyst, Jane Flax (1990), has commented on 'a conspiratorial silence among feminists' about mother/daughter violence, and has suggested that 'female aggression and longing for freedom are frequently inhibited as much by mothers as

by any patriarchy' (reviewed by Grosskurth, 1991:31).

As Rich (1977:242) makes clear, 'The woman who has felt "unmothered" may seek mothers all her life - may even seek them in men', and it is clear that this preferring of men over women can be seen as a rational and pragmatic response to observed gendered power-differentials. It is also likely to have darker and more unconscious roots, as Rich continues (1977:243-4):

'Many daughters live in rage at their mothers for having accepted, too readily and passively, "whatever comes". A mother's victimization does not merely humiliate her, it mutilates the daughter who watches her for clues as to what it means to be a woman. ... a daughter [is likely] to feel rage at her mother's powerlessness or lack of struggle - because of her intense identification and because in order to fight for herself she needs first to have been both loved and fought for.'

This issue - of daughters experiencing their mothers as simultaneously responsible for them but also powerless to protect them - is explored in two stark examples: sexual abuse and physical abuse.

Powerless responsibility: childhood sexual abuse

As noted earlier, respondents were not asked specifically during the interview about issues such as previous sexual abuse, although for those respondents who completed the Trauma Index (n = 22) there was a question asking if they had been abused as a child and if so at what ages. Two women disclosed this information only on the Trauma Index and two did not complete the Trauma Index but

discussed the abuse during the interview. Altogether, nine women discussed issues of childhood sexual abuse during the interview, with a further two, as mentioned, disclosing the abuse only via the Trauma Index. Thus eleven women out of forty-eight gave information on childhood sexual abuse.

The link between childhood sexual abuse and subsequent drug or alcohol use has recently received increasing prominence in the literature on 'dual diagnosis' which shows high levels of childhood sexual abuse among adult substance users (for example, see Harrison et al, 1989; Dembo et al, 1989; Bollerud, 1990; Young, 1990; Barrett and Trepper, 1991; Bean, 1992; Chiavaroli, 1992; Winick et al, 1992; Boyd, 1993; Watts and Ellis, 1993; Coppenhall, 1994; Simpson et al, 1994). For example, one study, (Porter 1995) of a sample of 60 patients attending a detoxification unit in London, found that half of the sample of 20 women and a quarter of the sample of 40 men had experienced 'contact sexual abuse' before reaching the age of 16.

However, the literature tends to focus on screening and treatment issues among treatment samples, without an examination of how the sexual abuse affected the women's daily lives within their families, and there seems little interest shown so far in effects other than individualised psychiatric outcomes. For example, Chiavaroli (1992:349) cites studies giving the 'observed correlates' of sexual abuse as 'substance abuse, low self-esteem, impaired social skills, suicidal ideation, promiscuity, and withdrawal', with no reference to the impact on the survivor's family relationships. Again, Boyd (1993:437) in a study of African-American women using crack cocaine, suggests that agencies should 'whenever possible' offer family therapy, but solely in relation to *substance-abuse* with the family,

rather than the continuing emotional consequences of previous sexual abuse.

Barrett and Trepper (1991) using a multiple systems perspective and a feminist power analysis of sexual abuse, and Winick et al (1992:314), would seem to be almost alone in tentatively suggesting therapy sessions which include the family of origin, or in even noting 'how the survivors feel about their mothers' as a relevant therapeutic topic, while Coppenhall (1994:200), interestingly, lists 'hostile interactions with older women' as a short-term effect of childhood sexual abuse.

Among this sample, it was clear that their experience of sexual abuse had often resulted in a very tense and painful relationship with their mothers. This, given the salience of the mother-daughter relationship in society generally, indicates that this is a key finding and suggests that the reverberations of this damaged and ambivalent relationship are likely to echo far into adulthood.

Among the nine respondents who discussed their abuse during the interview, only Carrie's mother was not living at home at the time of the abuse. The other eight respondents talked about the responses of their mothers, either at the time of the abuse or recently. Their main emotion regarding their mothers seemed to be a sense that their mothers had not protected them.

Anita talked about the abuse of both herself and her sister, which continued on weekend leave even after Anita had been admitted to a psychiatric unit at around fourteen:

'Me and my sister told my mum, but she wouldn't believe us. -- We used to pretend, we used to say "Oh, someone come in the room, didn't they." but then in the morning we'd say nothing, knowing

what happened, cos the drawer would be moved and other things would be changed. -- my mum feels I left home [at sixteen] cos me dad's gone and she'd say, "Now you're doing the same, you're going as well." But I weren't, she didn't understand what was going on. You know, on my weekend leaves, I used to still get - I hated coming home at weekends, I hated it. I couldn't believe it, it was still happening. -- [Our mother] just didn't believe us. We wanted a lock on the room, but she found some dirty magazines, me and my sister got the blame, saying they were ours, she said. She wouldn't give us a lock for the room, bedroom door. Eventually she did give us one, cos we think she knew what was going on, but - I don't know, I don't know what she thought. She just didn't believe us. We were nothing [small laugh] sort of, shut up and get on with the housework thing, don't talk. The worst thing I ever did was get into the psychiatric hospital, for them that was bad! [small laugh] You're not supposed to discuss the family, you know, why are you behaving the way you are?' (026a:2,3,5).

Beverley recently confronted her mother during a visit, when she had drunk a bottle of spirits. Her mother referred to her as 'that fucking junkie, that alcoholic - she's evil':

'That started me off. I said, "*I'm* evil?!" I said, "Do you want to know why I've hated you all these years?" -- I started remembering bits -- And she just sat there gob-smacked and I lit another cigarette and then I said to her, "And then you wonder why I drink and

fucking take drugs.” I said, “If you’d had been there when I needed you then things wouldn’t have happened like this.” Then she said, “But I was there, I was there.” I said, “You weren’t there when I needed you most, when my dad interfered with me you weren’t there.” [Mum looked at her older sister, also in room] My mum said, “She’s your sister, sort her out, sort her out, hit her.” And my sister looked at me in a way that - a weird way, and I thought to myself “If you get up and hit me, I’ll fucking kill you”. That was just *my* time for *my* say and they were listening whether they wanted to or not. I don’t care. I’m speaking and they’re listening. And then my mum says something to my sister and my sister says, “Well, the same thing happened to me too.” (001b:1)

Beth recalled that when she was thirteen she was raped by a family member. The actual rape was preceded by a series of incidents:

‘and when I told my mum and things like she didn’t really believe me. She thought I was fantasising, I think. And everything I said she took very lightly and that. -- [after the rape] my mum told me that I had to deny everything and that because unless I made the official complaint nothing could be done anyway. -- And I think that she should have screamed and shouted and had him done. But instead like I was told to keep my mouth shut. -- The main thing was for it to all be hushed over and shoved under the carpet type of thing. Not to make a fuss and that and I think that that’s where things went wrong for me.’ (011:7)

Cathy was involved in prostitution from the age of fourteen and recalled that her mother, who knew about the prostitution 'just called me all the names under the sun and just kicked me out. That was when I was fifteen, like, you know. -- She said she was physically sick when she [found out] and all that sort of thing. And I thought, well *any decent mother*, they'd have called in the police or something like that.' (037:16,17, italics added)

Chris, like Beth, was raped at thirteen by a family member. She said, 'I felt so alone. Because I didn't know - I couldn't talk -- I didn't know how to tell anybody. -- So I just bottled it up, never told anybody for two years.' (014:7)

Deborah recalled, 'I was being sexually abused by [family member] from three until about the age of seven. -- nobody really paid much attention really as to any of it really if you know what I mean.' (012a: 4). Later she described poignantly, 'when I used to look at like *me*, like what's inside me, I used to like just have a vision like this little picture. Just like a little girl, you know, up a corner. Like dead hurt and dead upset and, you know, dead neglected kind of thing. And, you know, just scared of like saying or doing anything.' (012b:20)

For Meg:

'My mum did her best but I was - I had a lot of, um, problems. -- [male family-member] abused me from the age of five to sixteen. I had to have an abortion when I was fourteen. -- I mean my mum knows now. I mean, like this last year. And actually, to tell you the truth, I got pissed out of my brains to tell her. -- And I mean the response I got from her was, well you weren't the only one were

you, he did it to [sister] as well. You know. And I thought thanks for your support, mum. You know. So we don't talk to one another any more for that simple reason. -- I mean if I went to my mum's tomorrow and said, you know, I need to talk about it, you know, you're not allowed to mention it. -- I've got an idea that she did [know]. And that's probably why - this is her guilt. This is her way of dealing with it. By not talking about it. Because she knows that she was wrong. She could have stopped it.' (028:8,10).

Patty was abused by at least three different males, from the age of about three upwards, and said 'I was close to my mum. You know. Except I couldn't talk to her about this. Because I felt it would hurt her. So I never really talked to her about it. -- I felt quite alone when I was a kid.' (024:6)

This sense of expecting protection from one's mother - and a sense of betrayal and pain or anger when the protection is not there - is often accepted unproblematically in the literature on sexual abuse. One highly influential work, by Forward and Buck (1981:37), referred to the mother as the 'silent partner' and asserted that 80% to 90% of 'victims' mothers are 'involved in the incest' on a conscious or unconscious level. This influential view of the 'collusive mother' has been challenged by feminist analyses of sexual abuse (see, eg, Nelson, 1987; Driver and Droisen, 1989; Mahood, 1995), which have pointed out that women's position in patriarchal society does not empower them to protect their children effectively.

Women who accept the traditional role of wife and mother are caught between the two socially prescribed roles of loyalty and submission to one's husband and protection of one's children. Positive action in such a dilemma requires from the

mother 'an assertiveness she has learned not to practise, and which she is ill-equipped to adopt.' (Nelson, 1987:73).

Sexual abuse can be seen as intrinsic to the wider patriarchal project in that it socialises girls to be subordinate, to feel guilty and ashamed and to tolerate, through fear, the power exercised females by males (Rush, 1980). This process is achieved at the level of the child's developmental psychology, where the abuse causes the developing self's capacity for trust, autonomy and initiative to be destroyed and replaced by an inability to trust in one's own perceptions, and thus to interact effectively with one's environment, which in turn impedes the development of a sense of oneself as valuable in one's own right. The healthy maturational process of *individuation* is thus replaced by a damaging experience of *fusion* with the needs, expectations and requirements of the abuser, leading to long-term consequences of a sense of powerlessness and subjugation (Young, 1990). While this process can perhaps be seen at its most stark in the case of sexual abuse, it is clear that this general psychological process of 'fusion' rather than 'individuation' is not confined to girls exposed to childhood sexual abuse, but actually falls within the broad pattern of female socialisation typical under patriarchy (for example, see Gilligan (1982) on the gender-differentiated development of moral systems).

Another aspect of sexual abuse which is not apparent from the literature but is salient in the lives of the respondents is the ongoing proximity of the abusers in the women's lives, as well of course as the continuing relationship with their mothers and other family-members. For example, it is known from the interviews that the abusers included three brothers and a step-brother, two brothers-in-law, an uncle, a

father and a step-father, as well as two male 'friends'. The respondents talked about their discomfort and anger at seeing these people still around, both at special family gatherings such as funerals and in daily life. For example, one respondent, as an adult on a visit to her family-home, was left alone by her mother with the abuser brother: 'He was carrying on like nothing was wrong. I felt inside, "It's cos of *you* I've had to do -", you know. I was just so angry but I couldn't say nothing.' Some of the respondents knew that these men had gone on to abuse other girls and women, and expressed a sense of guilt and responsibility that they had not been able to prevent this. None of the abusers had been convicted, or even taken to court, and the respondents expressed anger and frustration that the abusers had been allowed to just 'get away with it.'

Feminist theorists have pointed out how, both structurally and inter-personally, power can be used by the abuser to permit the abuse to take place (Driver and Droisen, 1989). As small children, we fantasise that our mothers are all-powerful, that they can protect us from all harm (Ruddick, 1990). It is therefore not surprising that the respondents felt that their mothers should have been able to protect them - and neither is it surprising that in fact their mothers, inextricably entangled within a systemic patriarchal degradation of women, were able neither to protect them at the time nor to offer them support later, or in any way to acknowledge the long-term dynamics of a family containing both abusers and abused into adulthood and beyond.

Powerless responsibility: childhood physical abuse

Two respondents volunteered the information that they had been hit by their mothers, and three further respondents volunteered information on physical violence directed at their mothers by male partners. Particularly where their own mothers were the targets of male violence, respondents were left with a sense of helplessness and guilt.

For example, Anita remembered, 'My dad used to beat my mum up a lot as well. -- Everyone was scared of him, like all of us kids were scared of him. We used to say to the older brother, "Can't you go down and stop him hitting Mum?", and he'd be just as scared. -- we'd be upstairs, you know, hands over our ears to try and block the noise out. I used to hate it, wished I could go down there and stop it.' (026a:2)

Heather recalled a similar sense of hopelessness, but in this case she had a greater sense of her mother protecting the children as well:

'my mum had 22 years of my dad beating her up and coming home drunk -- it was horrible. He used to come home every night and drag my mum out of bed and beat her up and throw her down the stairs and stuff. And it got to the stage where we had some bushes next to our house -- my mum used to - about say half ten she used to wrap us all up in blankets and we'd go and sit in the bushes until my dad went in and the lights went off. And then we'd all go back in. It was that bad.' (021a:4,5).

Summary

What emerges from the data in this chapter is a general picture of women who, in Adrienne Rich's (1977:225) evocative phrase, often feel 'wildly unmothered' and unprotected themselves, having frequently experienced childhood that did not meet their basic needs to be nurtured and protected from physical, sexual and emotional violence.

This lack of a firm experiential grounding in how to mother successfully gives the women a heightened sense of concern over their own mothering abilities, which they often appear to feel they are having to learn from scratch. Without an adequate yardstick against which to measure themselves, the respondents find it difficult to realistically gauge their own mothering competence, and hence to confidently take control of their mothering responsibilities.

These issues are explored further in the following chapters, which focus on the respondents' experiences of mothering. Chapter Six investigates the social context within which substance-using mothers care for their families, and Chapters Seven and Eight look more closely at the respondents' relationships with their children.

Chapter Six:
Taking Control, Losing Control:
The Everyday Context of Respondents' Lives

Introduction

This section explores the everyday context in which the women brought up their families. Underlying many of the respondents' accounts is one particular narrative, repeated many times in different ways by women with very different histories: a narrative of taking control, losing and struggling to regain control, of battling to be 'normal', to live a normal, everyday life as a woman and mother, in the face of forces which disrupt and frustrate all her attempts. Frequently the respondents' efforts at maintaining their family lives are jeopardised by repeated violence and by substance-using partners, whose goals may be at variance with their own. The women both struggle to maintain normality and are burdened by guilt and shame that they have not achieved it - they are faced with the paradoxical image of themselves as simultaneously both the houseproud wife and caring mother and the 'dirty alkie' or 'junkie'.

Many of the respondents exemplify this narrative of 'taking and losing control', or attempting to maintain a 'normal' home-life in the face of disruptions, but it is possible to use one example, Stella, in order to identify some key points of this narrative.

A case-study: Stella (age 31, with partner, three children ages 13, 11 and 7 years)

Stella comes from what she regards as a stable, happy family where she is the odd one out, the 'black sheep' of the family. She left school and went straight into employment, leaving her job only to have her first child once she was married. She lived as a happily-married mother of two until the marriage broke up when her husband had an affair. As she describes it, 'I was doing everything right - I didn't know anything except how to rear my children and look after my husband. -- I had no choice except to do what was expected of me, and I was happy doing it, I just didn't know anything else and then when he was gone, there was a big world out there and I got lost.' (004a:1)

Fairly soon after, Stella met and married her second husband and had another child. However, her husband soon became very physically violent and Stella had to escape, taking her children with her. Since that time, she has been homeless and awaiting accommodation. Nevertheless, she had until the last few months managed to hold down a responsible job and care for her youngest child, while her other two children returned to live with her first husband, which she found very hard to bear.

Her narrative of a normal stable home-life is thus disrupted twice, once through the marriage break-up and again through domestic violence, which results in the loss not only of her second marriage but also of her home and two of her children.

Stella at this point almost gives way to despair: 'I had the torment of losing my other two children to my other husband. I just felt I'd failed. -- I was defeated then. I couldn't cope. I even tried to commit suicide then.' (004b:15)

Throughout this narrative, Stella emphasises again and again her desire for normality, not 'some kind of fairy-tale', but to be a normal wife and mother:

'I lost a very nice house through domestic violence and I turned to drugs. -- It's things like [the housing problems] that make me take drugs, because I feel ashamed. I am ashamed. I've got morals, but I'm not having the opportunities to prove .. you see, my home, I haven't got a home. -- I know my son deserves better, but I'm the only one who can better him and nobody's [helping]. --We're not looking at some kind of fairy-tale. I'm looking at something that's simply possible. All I want to do is have a house.' (004a:1-2)

She continues: 'Because with me waking up every day knowing that I haven't got a *home* ... you see, ideally I want to wake up and do housework and cook the tea ready for my man and kids and all that. *Here* I wake up with a gut feeling and that's another reason why I take drugs, because of how much of a hole there is in my life at the moment.' (004b:3) Stella finally obtained a two-bedroomed Housing Association house out of the main drug-using area, and was delighted. Her drug-use reduced significantly and her life settled down for a while. She eagerly looked forward to everyday activities: 'Now that I'm here, half of my money will be on the bills, which I'm glad for, I'm really glad for. I can't wait to pay a gas bill! Or an electric bill! Cos it will make things more normal'. (004d:6)

However, even when settled in a house, Stella found it difficult to be the housewife and mother she wanted to be. Like many women, she found that responsibility for the household finances and chores devolved onto her while her partner (also heroin-dependent) although the main earner, tended to abdicate any other

responsibilities. She praised him as a traditional breadwinner, saying 'he works damn hard and all he really does care about is me and the kids, and he's really good like that.' (004f:6), but tensions remained.

As she described it eloquently, the difference between male and female drug-users is that:

'a man will just concentrate on getting the drugs, whereas the woman will concentrate on "How am I going to get the tea and do this and that?" Men just don't think of what's in the fridge for tea, where that is really important when you've got kids. -- my partner isn't aware [of bills] and if I bring it to his awareness, it's like "Oh don't worry, that'll be done" and I'm left with "*Will* it be done?" I'm left with "*When* is it going to be paid?" and if I ask again, I'll be shouted at, so I tend not to ask, and just worry about it - and try to do it. What I'll do is like is if he gives me £20 to go and get some shopping, and I'll spend £10 on shopping, and £10 on whatever I have to.-- He's the one who controls it and earns it, which I prefer that way, cos he knows how much money there is in the kitty, and like I just worry about taking it out, he worries about putting it in, I suppose. ... It is traditional, but it's still not how I want it.' (004e:1)

What this narrative exemplifies is the way in which Stella, like many other respondents, continued to adhere to a ideal of normative family life despite a range of barriers which continually impeded her ability to attain this ideal. The barriers in her account include domestic violence, homelessness, and separation from her children. Other respondents mentioned further barriers such as poverty and debt,

going into prison or residential rehabilitation, involvement with crime, and their own status as a 'junkie'. In addition to barriers such as these, Stella also has a problematic relationship with household finances which are accessed via her partner, although she appears to retain responsibility for bills and everyday shopping and expenses. These barriers will be explored in greater depth in the remainder of this chapter, taking into consideration also some social contexts which may assist women in maintaining a normative family life.

Barriers to taking control: poverty, debt and deprivation

Theorists such as Graham (1984b, 1992) have discussed how poverty acts as a barrier to mothers' ability to exercise choice and control over their lives. In this study poverty and deprivation certainly acted as major constraining factors. Of the 25 respondents who completed an index of deprivation (as part of the checklist research instrument), four respondents were living in temporary accommodation and twenty were renting accommodation from the local authority or housing associations, while only one respondent was a home-owner. Fourteen lived on income support, and a further eight on income support and some form of disability or sickness benefit, while only three were not on benefits but lived exclusively on their own or their partners' wages (four combined wages and benefits). Possession of items such as cars and telephones tended to come and go over the course of interviewing (as cars broke down and telephones were cut off), but at the point of completing the index of deprivation, thirteen of the 25 respondents did not have telephones, and twenty-one did not have a car. Only six of the respondents were known to have full car-licences, while eighteen were known not to have.

If we compare indices of disadvantage with the study by Graham (1993a) as shown below in Figure 6, we can see that, as in her sample in which heavier smoking correlated positively with the presence of three or more indicators of disadvantage, in the current sample of 25 substance-using mothers, only five had less than three indicators of disadvantage, and twenty respondents had three or more (See Figures 7 and 8, overleaf, for indicators of disadvantage reported by respondents, and numbers of indicators reported per respondent). This is even when using a fairly generous interpretation of 'full time job' to include occupations such as cleaning and bar-work, but including temporary accommodation in the definition of 'bed and breakfast accommodation'. Thus, as with Graham's (1993a) finding that heavier smokers are likely to live in poorer material circumstances, this study provides evidence that substance-using mothers are also likely to live in very poor material circumstances.

Indicators of Disadvantage
(taken from Graham, 1993a)

No-one in the household employed

No car available

No telephone in the accommodation

Having debts

Bringing up children alone

Never had a full-time job

Having lived in bed and breakfast accommodation for more than a month

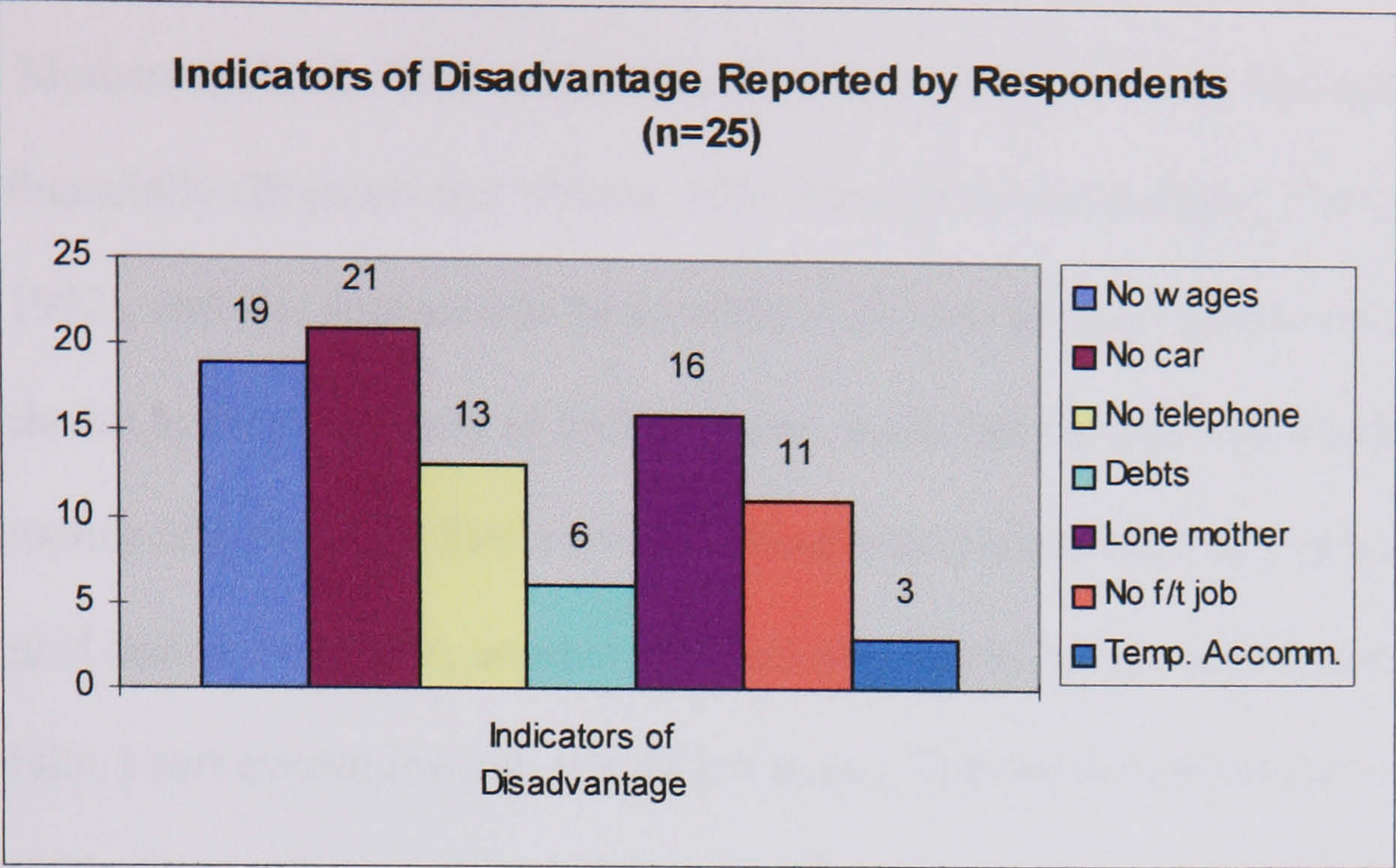
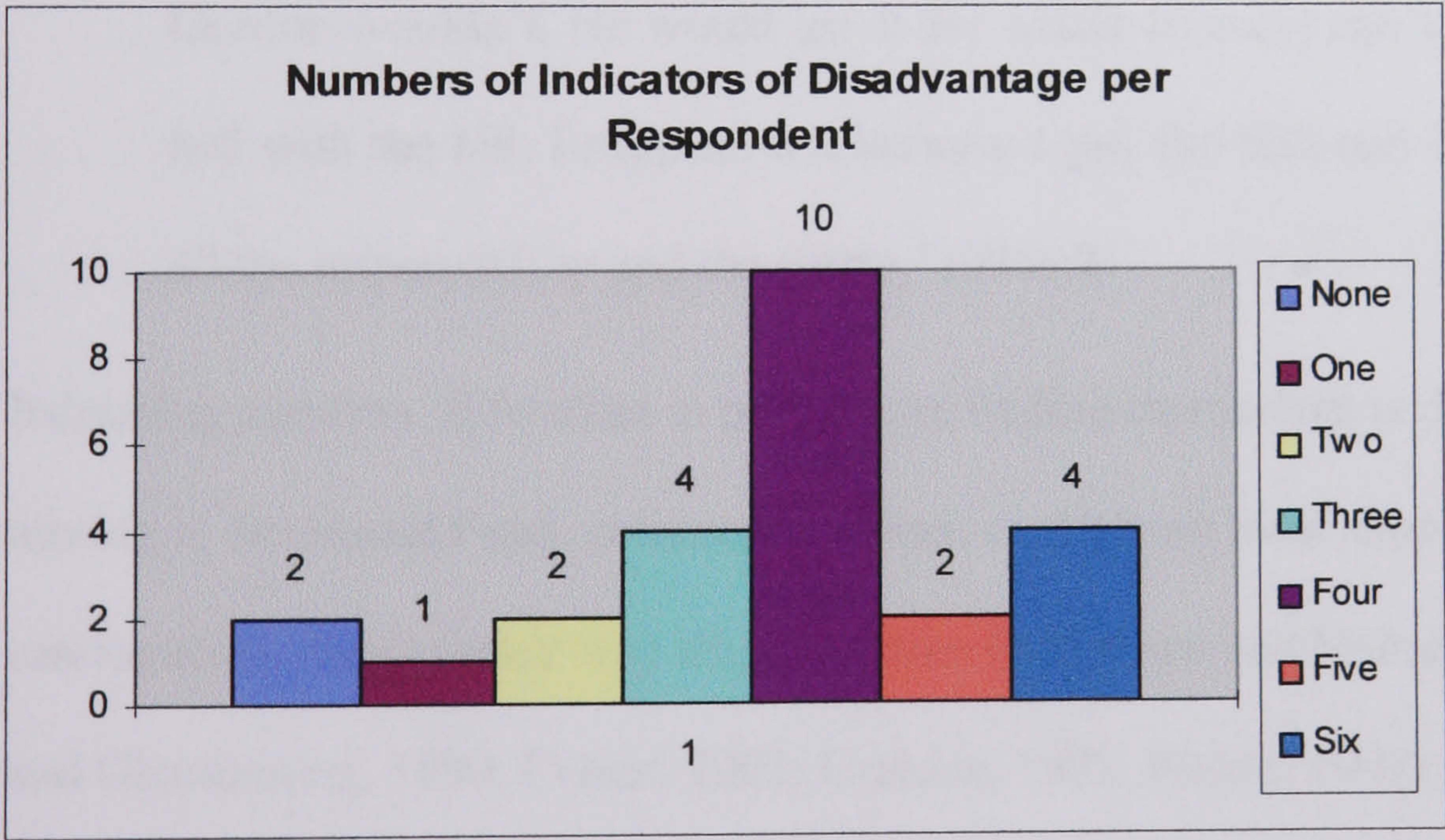


Figure 7 (above) shows the incidence of indicators of disadvantage, taken from the study by Graham (1993a), which were reported by respondents (n = 25).

Figure 8 (below) shows the total number of indicators of disadvantage reported by each individual respondent (n = 25).



Mothers typically have to shoulder the responsibility for making ends meet financially (Brannen and Wilson, 1987; Bradshaw and Holmes, 1989; Graham, 1992), and this appeared to be a common pattern among women in this study. As shown in the case-study of Stella, above, while her partner worries about putting money into the kitty, Stella worries about taking the money out, ensuring bills are paid and so on. Again, another respondents, Annie, complained bitterly 'I pay the bills. I sort everything out. It's all left to me. The responsibilities are down to me.' (003a:3), and Donna also spoke about shouldering all the responsibility:

'I like me bills paid and I mean even when we were using before, Gordon would use the last of the money for a hit. I wouldn't. That was the difference between us. If there was £25 left which was for shopping or a bill I'd get the shopping or pay the bill, whereas Gordon wouldn't. He would use it for smack [heroin] and what the hell with the bill. I suppose it's because I pay the bills and I've got all the responsibility and the worry.' (008a:8)

Increasing numbers of families in poverty are finding themselves in debt, and turning to the Social Fund, commercial loans, credit from local shops, or catalogues to finance their way through crises (Bradshaw and Holmes, 1989; Craig and Glendinning, 1990; Cohen, 1991; Graham, 1992; Parker, 1992). Use of the Social Fund or commercial loans did not appear to be widespread among respondents in this study, whereas illegal loans, with one's Income Support book as security, or the use of catalogues (not always paid back) seemed more common. This may have been due to the difficulty in ever paying off a loan once acquired. As Marlene described her use of the Social Fund:

'I'm living from loan to loan. When I get in a mess I have a loan. Not a crisis loan, but I ask for a budgeting loan or something or other. And usually half of that I would spend on getting some bills out of the way, and the other half would probably go on drugs or drink or whatever. So I'm on loan number twenty-something now, I think.' (007a:3)

In this study, six respondents mentioned being currently in debt. However, this figure does not represent the true picture of respondents' financial position, since the debts mentioned refer only to official debts for utilities, rent and so on.

Respondents also, as part of daily life, often had a pattern of lending and borrowing small amounts of money, £5 or £10, within their social network, often to and from other women, so that there appeared to be a constant backwards and forwards movement of small amounts of money to tide one another over each week once the benefit book had been cashed. In addition to these fairly friendly borrowing arrangements were more sinister debts, where respondents talked about having to hand over their total Income Support money as soon as they had cashed it at the post office, or giving their Income Support books as collateral for a loan from an acquaintance. This issue has not been much discussed in the literature, but two studies refer to extortionate loans being secured on child benefit books (Crossley, 1984; Ford, 1991).

For many families in poverty, the wider kin network often assists when times are hard (Wilmott, 1987; Bradshaw and Holmes, 1989; Craig and Glendinning, 1990; Ritchie, 1990) and again, as we saw in Chapter Four regarding childcare, it is often grandmothers who are the lynchpin in providing such help. A majority of families

still appear to live near to their family of origin (Graham and McKee, 1980; Bell et al, 1983; Ribbens, 1994). As Graham (1992:221) expresses it, 'most of the day-to-day help received by mothers comes from other women, from female friends and female relatives'. Within this, it is frequently the woman's own mother who will often give gifts in kind, such as food, hot meals, and clothes for the children (Graham, 1985a).

This pattern was mentioned by only two respondents in this study. For example, Chris said: 'I go to my mum's like every Friday until say Monday -- [I: Does she cook for you?] Yeah. That's basically probably why we go down there. Because there's always food there. She always cooks.' (014:9)

Donna discussed turning to her mother-in-law for help, in the context of her partner not taking responsibility for childcare:

'I would never see the kids go without food or something to eat, and [baby] was only a little 'un and I hadn't got any nappies, or I'd got a couple left, so I'd got my Monday money book and there was about £21 there to cash and I thought - I was going to a friend's - shall I take this book with me, and I thought no, he won't cash it cos he *knows* I need nappies, and I've got no money apart from this. Come home, they've cashed it, him and his brother. Whereas I'm not like that, I was never like that anyway. But he is, I'll spend it and think about it later sort of thing. Cos I suppose - I dunno - I think the woman's got the most responsibility. [I: Do you think it's a man/woman thing?] Yeah, because I suppose - I can't see his way of thinking - but I suppose he's thinking she'll manage, she'll sort

something out, but that's not fair on me, cos half the time I couldn't manage. I mean - that day I had to phone his mum and dad up and tell them, and I never do that, I never ever do that. And they brought me some nappies and potatoes and food and that, but if it weren't for them - I mean I can't go to *my* mum for help cos she doesn't know anything! None of my family do.' (008c:7)

As we have seen from Chapter Five on respondents' experiences of being mothered, many women in this study had very difficult relationships with their families of origin, and thus few were able to turn to a resource which otherwise appears to be generally available in the wider community. As Patricia described it:

'whereas normal families you have all the back up from grandparents and brothers and sisters. And we just don't have any help or any back up and, um, you know. It's just the kids all the time. I think we've been out like once I think in about the last three years now, you know.-- All my family lives [locally]. Uh. I've always been the black sheep of the family I suppose. Uh. So you don't get any help or support or anything like that you know. Cos I ran away from home and, you know, I've been in care and blah, blah, blah, and whatever. And, uh, you know, there's never been any sort of help or support, anything from home, you know, nothing. Absolutely nothing, you know!'

 (006a:3,4)

Thus substance-using women may be even more vulnerable to the effects of poverty and deprivation than other women in the community, since they are more likely to be in ongoing financial difficulties with constant demands on their money

to pay for their substance of addiction, and also to have problematic relationships with their families.

Barriers to taking control: domestic violence

A key variable in the process of successfully taking and retaining control was revealed by the data as being domestic violence, experienced by well over half the total sample. However, there are serious difficulties for substance-using women in accessing refuge accommodation (Blane, 1995; Elias, 1996; Goode, 1997) because of bans on alcohol and illicit drug-use within the refuges.

The linkages between substance use and domestic violence are increasingly being explored (see, for example, Bennett, 1995; Richardson and Feder, 1995; Elias, 1996; Goode, 1997), and the evidence from the literature suggests that cross-linkages between substance-use and domestic violence are a major issue for the following three reasons: (1) anecdotal evidence suggests that approximately 50% of perpetrators of domestic violence use substances, usually alcohol, before committing offences (Elias, 1996); (2) women substance users are especially vulnerable targets for violence (Miller, 1991); and (3) women who are victims of violence are at high risk for substance-use (Russell and Wilsnack, 1991). Figures from studies suggest around 60% of female substance users are victims of domestic violence (Bennett and Lawson, 1994). Treatment providers are now beginning to acknowledge the prevalence and consequences of such high levels of domestic violence inflicted on substance-using women. Feminists in particular are responsible for alerting professionals to the existence of post-traumatic stress disorder as a response to such devastating assaults on the psyche (Dixon, 1995), and treatment providers are now starting to identify the symptoms of post-

traumatic stress disorder among their substance-dependent women clients (Fullilove et al, 1993; Brady et al, 1994; Hien and Levin, 1994).

In this sample, as noted on page 43, twenty-five of the respondents (52%) were classified as having either boyfriends or live-in partners, with a further five women who moved in or out of relationships during the course of the interview-series, and one further woman recently separated from her husband, making a total of 31 women (65%) involved in some level of relationship with a male during the course of the interviews. (Of the two respondents who defined themselves as gay, both of these were not in a relationship during the research period.)

As a crude analysis of the respondents' experiences, it is possible to say that 29 of the 48 respondents either were now or had previously experienced physical abuse by a partner, and three both currently were and previously had, thus giving a total of 32 out of 48 respondents (67%) with experience of domestic violence.

This analysis is crude because it conflates the experiences of the two women who had experienced one single attack from their partners with women who had endured many years of extreme violence from one or more partners. This figure also does not include the women who had been beaten by family members or casual acquaintances although, as Theidon (1995:664) observed, for many women drug users the problem is not only partner violence but the 'ambient violence' within their neighbourhoods (and see also Barnard, 1993 on the specific problems of violence encountered by those working as streetworking prostitutes). The research attempted to overcome this last problem by asking, on a later version of the checklist, whether the respondent had 'ever been the victim of physical violence/assault by partner, stranger, or other'. Of the thirty respondents who filled

in a checklist, however, ten completed the earlier version which did not contain this question, and not all data were completed, leaving only thirteen women who gave a response to this question. Of these, three had only experienced violence from a partner, two from an 'other', three from partner and 'other', four from partner/s and stranger, and one from partners and her family. Thus eleven of the thirteen women who gave more detailed information had been physically assaulted not only by their partners but by others as well. Including the two women attacked by 'others' but not by partners, 71% of the sample had experienced physical violence.

There is increasing evidence of the use of physical violence on women during pregnancy (see, for example, Amaro et al, 1990; Berenson et al, 1991; Berenson et al, 1992; O'Campo et al, 1994; Stewart, 1994; Theidon, 1995). In this study, for example, both Lisa and Sally talked about being beaten up by their partner when eight months pregnant, and Angela reported that she had been beaten up by acquaintances many times and this violence had not stopped in pregnancy. She estimated she had been beaten up on six separate occasions during her pregnancy, the most recent having been when she was about seven months pregnant. For four respondents, this violence (by partners, neighbours or strangers) had caused miscarriage or death of a total of seven of their children. In addition, a further child had been deliberately poisoned to death by the child's father.

There were other, less extreme but also tragic, effects of domestic violence on children. In the respondents' accounts, the violence often seemed to occur when the children were small, and the male partners - who were usually also the fathers of the children - seemed to pay as little regard to their children's welfare as they did to their female partners. One study (Stewart, 1994) has indicated that women

physically abused during pregnancy are likely to suffer a significant increase in the abuse within three months of the baby being born, and certainly in this study a minimum of fourteen of the 32 respondents attacked by partners had had babies or small children with them at the time of attacks. This was discussed by Carrie, Cathy, Deborah, Hilary, Joyce and Meg, of which two examples, from Carrie and Meg, will suffice to provide a sense of the level of violence being discussed. Carrie described how, 'I've got one baby in one arm, another baby in another arm and he's throwing a big electric fire at us and plates, and they're babies. Do you know what I'm mean. They're babies!' (025b:24). The response of the police in this case was to threaten her with loss of custody of her children, with no attempt to assist her in removing her partner from her home. As she ironically commented, 'They're saying to me "We're going to have the kids took off you because he's so violent." And I'm saying, "Some help you've been."' (025b:24)

Meg recalled a typically violent episode:

'I'd just had Margaret and she was only a couple of weeks old and we took the kids out, had a nice afternoon, I put Tony up to bed while I sorted out the dinner. The baby wanted feeding and I said to him - all I said was "Either feed Margaret or dish the dinner up for me." And he went mad. He hit me, belted me as though he was hitting a bloke. He broke both my cheekbones, six ribs, my jaw, nose. Everything. He kicked me until I was black and blue. And he threw the pram with the baby outside and then belted each one of the kids.' (028a:10)

Maxine was alone in talking about how her stepson was protected from knowing about the violence: 'He [partner]'s always tended to be a bit violent when he's had a few -- broken jaw, broken nose, black eyes, you name it. -- But never when Thomas was around. It would always be when Thomas was on holiday -- So Thomas actually never seen any violence. I mean I told him I got mugged a few times! [laugh]' (036:7)

For Clare, the protection seemed to be channelled in the opposite direction, with her small son (aged seven) desperately attempting to protect her:

'he's only got to see him and he thinks straight away, "Mummy, you're gonna get beat up. Run, run, get the police." He panics, he automatically panics. Now how am I going to get him over that, each time he bumps into somebody that he feels I'm gonna get a kicking off them? -- at one point I couldn't even tell him that I'd moved home cos he was scared of me moving to the house on me own, that's why he was threatening to run away and all this sort of thing ... cos, cos he's seen me go through it, a lot of beatings and - and different upsets, he knows that it could happen again. It's always at the back of his mind that it could happen again ... and if he's not around he feels that he can't help.' (00C:12)

This small boy had already decided that not only was his mother unable to be protective but that it fell to him to be responsible for protecting her from male attackers. This issue of the 'child as responsible adult' is taken up in the following chapter.

Including the two women who were assaulted by 'others' and not by partners, we find that, of respondents using opiates as their main drug, 18 out of 28 had experienced violence from one ($n = 15$) or more ($n = 3$) partners, giving a total of 64%. Of those using amphetamine as their main drug, seven out of nine had been attacked by either a current or a previous partner and two by 'others'; thus all nine amphetamine-users had experienced violence. It is interesting that, of those using only licit substances such as alcohol or cough linctus, seven out of eleven, in other words the same proportion (64%) as opiate users, had experienced violence from a current or previous partner. This is a counter-intuitive finding given the assumption that opiate-users are likely to lead a 'rougher' lifestyle in a more violence-prone neighbourhood than women using only alcohol, but the very small sample size does not allow much weight to be given to this finding.

All those who mentioned childhood sexual abuse ($n = 11$) had also experienced physical violence as an adult, all from a partner and six from others as well, although this figure includes one respondent who had been attacked once only in the context of a long-term stable marriage. Again, as with the data on childhood sexual abuse, it is important to remember that the actual level of violence is likely to be under-reported in an interview-context.

Physical violence and its consequences clearly has many dimensions and the accounts that the respondents gave of their experiences included the dimensions of physical pain, fear, isolation, unpredictability, helplessness, loss of self-esteem, homelessness, humiliation, grief, and the response of professionals, such as the willingness of GPs to prescribe benzodiazepines for women in refuges. Fear and helplessness seemed the most salient dimensions in respondents' narratives, and it

seems obvious that, through the processes of learned helplessness (Seligman, 1975), women are vulnerable to sinking into depression and despair.

The fear is expressed by Carrie who said, 'He'd go and have a couple of pints and I'd be dreading him coming back, thinking "What's he going to do to me tonight?" -- So I'd be on me nerves and I couldn't eat and if I did eat I'd be sick and - oh, it was awful.' (025b:21)

Meg's account illustrates the fear and the helplessness arising from a lack of effective protection by the refuge, and the devastating consequences:

'he found out where I was -- he used to hang around outside -- I spent two and a half weeks in hospital because he was waiting outside and pushed me down the stairs -- And after that, after coming home and that I just fell apart and that was it. I went to pieces and that was when I started on Valium and drink. And the children were taken into foster care supposedly for two weeks while I got myself sorted out. -- I got the children back nearly twelve months later because I just went to pieces. I had to go to psychiatric [hospital] and tried to kill myself I don't know how many times. -- I was in that much of a state and I was so frightened, you know.'

(028a:5)

The accounts of the respondents clearly illustrate also the lack of effort made by the police to protect the women or deter the abusers. Respondents repeatedly spoke of the uselessness of obtaining injunctions or pressing charges against abusers. For Carrie, not until the police were literally standing behind the abuser,

hearing him threaten to kill her, did they take any action - he was subsequently charged with the minor crimes of damaging property and actual bodily harm. It was not the police but her next partner who protected Carrie from any more violence - a pattern repeated by other women who looked to male protectors (boyfriends, partners or sons) to protect them from male violence.

Barriers to taking control: housing instability

Living in insecure, temporary accommodation, moving home frequently, and being homeless can all be significant issues for drug or alcohol-dependent women (Zimmer and Schretzman, 1991). Five of the respondents in this study talked about having been into a women's refuge at least once, and seven referred to having lost their homes through their partner's physical violence, while another two, Chris and Carrie, were advised by professionals to leave but refused on the grounds that they would not be forced out of their own homes. Only two of those who lost their homes through violence also entered a women's refuge; the others found alternative accommodation, often with great difficulty. Altogether, therefore, almost a quarter of the sample (n = 11, 23%) were intimidated by violence into leaving or considering leaving their homes on at least one occasion and, for some women, this was a repeated experience.

For Stella, who was made homeless by domestic violence, the effects, as we have seen earlier, were devastating. She lived in hostels first and then temporary, low-standard accommodation in the centre of a drug-dealing area:

‘I lost a very nice house through domestic violence and I turned to drugs. -- I was smashing things up through frustration. Why should

I have nice things if I haven't got a nice house? -- It gets burgled all the time. I've got no [front door]. My landlord doesn't want to know. I'm struggling. I take drugs because physically now I'm addicted but it didn't start off physically. It started off through stress.' (004a:1)

For other respondents, their housing stability was compromised when they lost their homes through their own criminal activities (Angela, Deborah, and Gloria) or were forced to be 'on the run' when they refused to surrender themselves to the police after a warrant was issued for their arrest (Anita and Gloria). In addition, Beth and Marlene talked about how they were driven out of their homes by the criminal activities of others. Marlene could no longer bear to live in her flat after it was burgled by a friend, and Beth was forced, on police advice, to give up her house and move her children after someone known to her terrorised her by repeatedly breaking into the house, stealing items, and masturbating over her underwear.

Respondents also left their homes to be admitted to an inpatient alcohol or drug detoxification unit ($n = 11$) or to a rehabilitation centre ($n = 9$). Again, for some respondents, these experiences were repeated. For example, three respondents had been into detoxification units at least four times each, and three respondents had been to a rehabilitation centre more than once.

Respondents also left their homes when taken into custody ($n = 14$), either on remand or to serve a prison sentence. Eight respondents had been in custody more than once, with a range between two and twenty-four times. This finding is consonant with a recent study of women prisoners (Caddle and Crisp, 1997),

which found 61% of a sample of 1766 women prisoners were mothers of dependent children and/or pregnant, and 52% of the women prisoners had experienced a drug or alcohol problem. This suggests that women prisoners are thus more likely than not to be both substance-users and mothers, and indicates the significance for these women of taking them out of their families and into custody.

Not only did homelessness, admission to residential treatment or being taken into custody affect the respondents' ability to maintain a stable home-life: it also threatened their ability to continue as the primary carer for their children, as the following section demonstrates.

Barriers to taking control: separation from children

For Beth, who received a prison sentence twice as a mother, the effects were painful and disruptive to her relationship with her children:

‘I was sentenced to three years imprisonment -- I didn't get parole or nothing. --And then it was time to come home. That was the hardest part because the boys had been with my mum and it was just really difficult, you know. They'd been with her throughout this three-year sentence and I'd been in jail. I didn't see them through that time. Only once.-- And then suddenly I was back home and I think they were a little bit frightened and that. I think my mum resented me coming back because suddenly I was going to take the boys away. -- And I resented her having all the fun with them while they were so small. And then I was frightened in case they rejected me, which they did.’ (011:8-9)

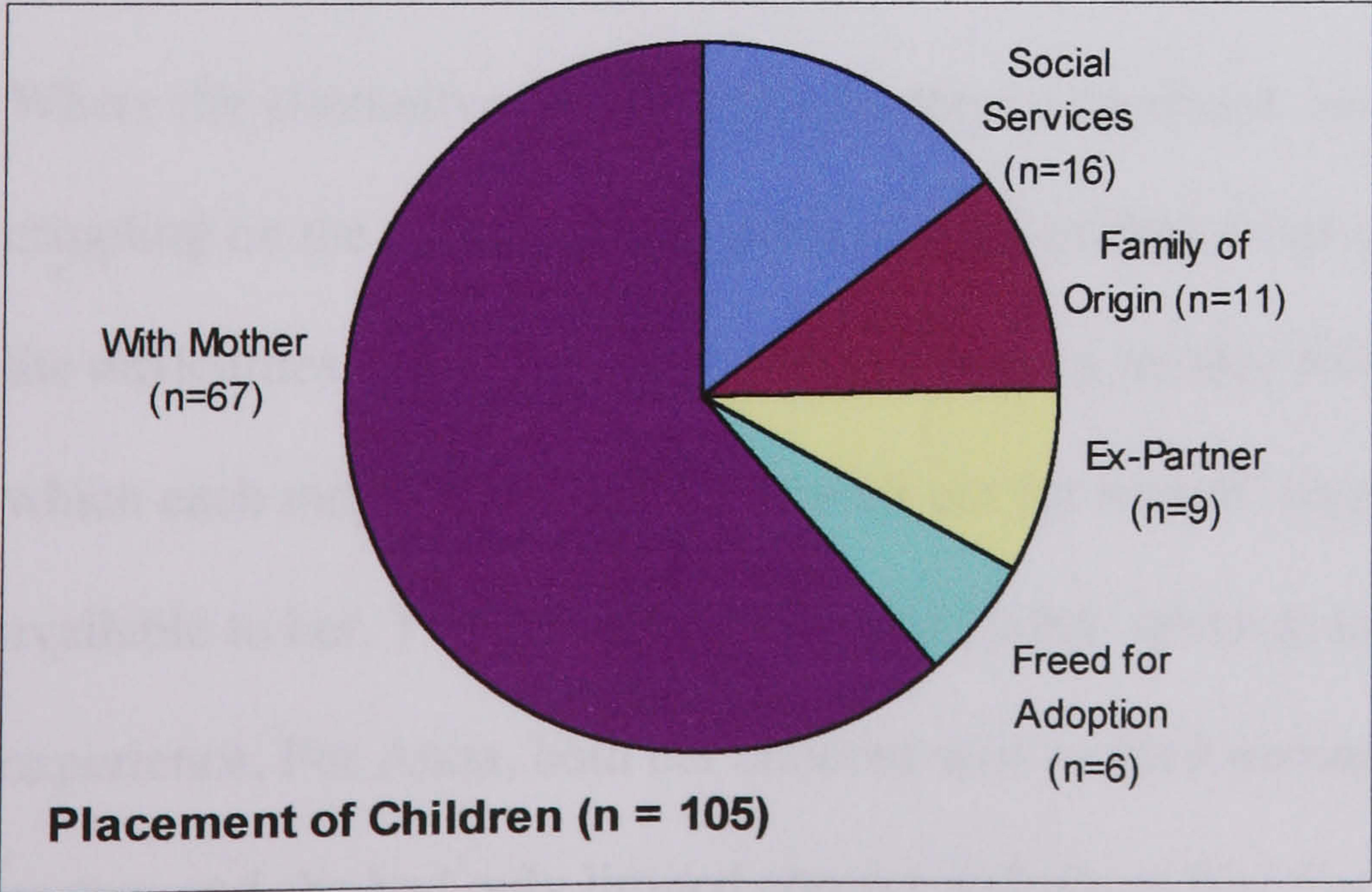
Deborah also spoke about the effects of prison, probation-hostels and social services on her relationship with her baby daughter:

'she's always known I'm her mum. Always. I mean I was in prison and none of them ever bothered bringing her to see me, and maintain contact for twelve months. Never. Never a birthday card off her. Never nothing. A letter, photograph, nothing at all. They just didn't ... As far as all they were concerned once I was away out of the picture, that was it then. -- After I come out after the twelve months I saw her and straight away she knew me, and she didn't want to be away from me neither, it was just making her more insecure. -- And then every time I come out of prison [the probation officer] was putting me as far away as possible, across borders of the country and fucking hostels where they couldn't have kids. So I couldn't have Agnes living with me. I couldn't afford to travel home every day to see her. So I never got to see her. So I got depressed again. Give up hope again and got into drugs again. Got into [shop]lifting again and got into prison again. -- I'd see her say one day out of every time I was out. -- But the first time -- because it was a mutual agreement between and [family member caring for Agnes] I had Agnes and I kept her for a week. They had the police searching -- social workers searching -- The probation service -- telling them all that the child was at risk. I was "very vulnerable", I was "in a right - erratic drug-user", blah, blah, blah. "We must get the baby back." I got arrested, they took her off me. -- Took me

down the police station and the social workers come and pick the baby up. And she screamed. That killed me. She clawed all me neck to pieces as they were dragging her off me. Bastards.’ (012b:4-7)

In addition to separations from their children due to prison sentences ($n = 6$)⁴, other respondents had children ‘looked after’ by social services ($n = 5$) or by relatives ($n = 10$) long-term, and four respondents had children freed for adoption due to their substance use. As noted earlier on page 42, of the total 105 children in this sample, 38 children (36%) of 22 mothers (49% of all the mothers in the sample) had lived away from their mothers for significant periods of time. Of these 22 families, in 6 cases the only child lived away, and in five cases all the children in the family lived away (ranging between two and seven children). In the remaining eleven cases, at least one child remained at home with the mother.

Figure 9 shows the placement of children. (Note: numbers total 109, not 105, as two children moved from ex-partner to social services, and two from social services to ex-partner, and are thus counted twice.)



⁴ Not all episodes of custody involved separation from children, as some apparently or certainly occurred prior to motherhood.

Altogether, therefore, twenty-two of the respondents had experienced one or more of their children living away from them for significant periods, either formally or informally, and for eight respondents this separation was considered (by the alternative carer if not by the respondent) a permanent arrangement. For other respondents, the arrangements were typically more fluid, usually with one child living away with a family member (often the respondent's mother or ex-partner) and other children still at home, and with the children moving between the respondent's home and other locations as situations improved or deteriorated.

Comments on the situation of children living away ranged from regarding it as broadly helpful to neutral to devastating for the mother involved, with the key variable in this perception appearing to be the level of control which the mother felt she had over the situation. Thus Gloria (015:36) discussed how, 'if I knew my kids was going to go into care I wouldn't rob again. But because I know they're not and they're looked after and they're with their nan and I know she's alright' she felt comfortable placing her children with her mother and continuing with her criminal lifestyle.

Where the alternative care was involuntary or regretted, however, the effect was crippling on the mother, and in particular the evidence from this study highlights the difficulties of negotiating the role of being a mother without her child - a role which each mother felt she had to work out for herself, since no role models were available to her. Two mothers, Anita and Cathy, spoke at length about this experience. For Anita, both her children now resided permanently with her ex-partner and she had only limited contact with them. For Cathy, her two children were in the process of being freed voluntarily for adoption due to Cathy's alcohol

problems. Thus both women inhabited an ambiguous status as neither mother nor not-mother. This is an example of Goffman's concept of discreditable status (1968), where the respondents' deviant status is not immediately apparent but they risk exposure during any casual social interaction, and they must choose either to disclose their stigmatising status as a mother without her children, or else attempt to pass as a non-mother. Cathy chooses to pass as a non-mother, while Anita chooses the strategy of avoidance in order to minimise social embarrassment, but both women feel excluded from the category of mother: they feel 'alone', 'a freak', 'different' from anyone else they know. As Cathy described it:

'I think if I could get somebody that would understand what I was going through I wouldn't feel so alone, you know. That sort of thing. And I think that would help me tremendously and that. That I'm not such a freak. That I'm not such a bad uncaring person, you know. Which I'm not. Because a lot of people, especially people like neighbours and things like that think "How could she do this? How could she do this to her own kids?" and all that, you know. And they do really scorn on you, you know. I've tried not to get involved with neighbours around here and that. -- now I'm just getting myself used to saying if somebody asks me if I've got kids then just say no. I've got myself used to it. I've hardened myself against it. But sometimes I do feel bad. -- I feel at the moment as if I haven't and that's it, although they are still there, you know. I know I've been a mother and that.' (037:26)

Anita similarly found it hard to work out how she should respond to everyday questions about her status. She preferred to tell the truth but found 'it backs people away':

'I'm thinking I'd like to go back to college and do a course and even go to work. I'd like to do something. Because otherwise it is boring. -- But I feel different from the rest of the people. -- The main thing is they ask you, um, questions like "Do you have kids or who do you live with?" And there's that thing that worries me. -- Because I feel I should tell the truth, that my kids aren't with me. But I've done that once and it backs people away. -- if they hear the kids aren't with me automatically they're going to think I'm really bad. -- you hear people who's got problems, yeah, but I ain't come across a mother who said she had kids but they're not with her any more, cos of drug-use. I've not come across that. Because I had two straight friends. -- I told them I had kids but they're not with me because of my drug-use. I told them because I had a drug problem. I've never seen them again after that!' (026c:9-10)

As these examples show, struggling with the contested category of mother or not-mother isolated the women and presented a barrier not only to re-building some form of family life but also to re-integrating themselves back into mainstream society generally, whether joining a college-course or just chatting with the neighbours.

The category of 'no-longer-mother', as these examples show, comes dangerously close to the category of 'evil mother', so that both Anita and Cathy constantly

struggled with the tensions inherent in maintaining a self-image of themselves as 'not such a bad uncaring person' when 'automatically they're going to think I'm really bad.'

Another contested and negotiated category which acted as a barrier to respondents' full participation in family and social life, and again one which slides perilously close to that of 'evil mother', is the category of 'junkie', which will be examined in the following section.

Barriers to taking control: the status of 'junkie'

The respondents' efforts to take and maintain control of their family-life was threatened not only by straightforward barriers such as homelessness or poverty, but by more diffuse social constraints such as the stigma of being a 'junkie mother'. A 'junkie mother' is in many ways a clear example of a 'problematic mother', exemplifying as she does attributes which threaten her legitimate inhabitation of the category of 'normative' or 'good mother'. This study revealed that respondents inhabiting the status of 'junkie' worked hard to contain and defuse the threat of expulsion out of 'good mother' into 'evil mother'.

The first problem for respondents was to define the status of 'junkie'. A key finding from this study involves the ways in which respondents achieved this. The status of 'junkie' revealed itself as a slippery concept, the definition of which became more extreme as women progressed further into heavy dependency. A distinction was often made between 'junkies' and 'real junkies'. Thus wherever on the continuum of opiate-use - and thus being a 'junkie' - a respondent might find herself, a 'real junkie' was usually defined as the next step along the continuum.

While previous studies have suggested that it is the act of injecting, the recognition of withdrawals or difficulty in finding a vein (Taylor, 1993) which constitute a status passage from 'non-junkie' to 'junkie', this study suggests that the status of 'junkie' is one which, especially for mothers, can be defined according to a cluster of components, and therefore can be viewed less as an either/or state and more as a point on a continuum from 'non-junkie' to 'real junkie', a shifting and ambiguous status which can almost always be compared to more extreme examples and is therefore constantly open to contestation and negotiation. This finding, while apparently in contrast to Taylor (1993), is consonant with Rosenbaum (1981a:54, 56, emphasis in original) who notes how the status of 'junkie' is linked to less to direct drug-use per se than to drug-related behaviour such as stealing from close friends or family or neglecting one's children, and that a woman heroin-user would 'taper the definition of herself as a junkie, redefining the term to mean simply one who is addicted and *not* a low-life or dog who will rip off family and friends ... [she was] an addict of a higher class.'

From this study, the definition of women who are 'real junkies' appeared to include the following components: injecting; injecting into more unusual and dangerous sites (hands, fingers, legs, toes, breast, stomach, groin, jugular vein); injecting more toxic substances; losing self-respect; not caring for their children, including social services' involvement; not keeping a clean house. There may also be the component of first registering as opiate-dependent, which Gloria described: 'people used to say, "Oh you don't want to get registered because you're known ever after as a junkie"' (015:35). Her partner was opposed to registering 'because of the stigma again, of being known as a drug addict' (015:35). There is also the

dimension of attitude: whether the drug-use is seen as arising from selfish hedonistic pleasure without regard for consequences (which would be highly compatible with the status of 'evil mother') or from 'need', to stave off physical withdrawal symptoms, and thus a burden or problem rather than a pleasure (thus not at odds with the status of 'normative mother', and other compatible statuses such as the medically-legitimated sick-role (Parsons, 1951), or membership of the 'respectable working class').

Beth provided an example of a mother who worked hard to distance herself from the category of 'real junkie' despite injecting into many parts of her body, which would usually have qualified her to inhabit such a category:

'I've injected into my fingers, my hands, my arms, my elbows, here. A couple of times I've injected into my breast. My legs, my feet, here. I really have. I've done the circuit. -- I've only injected into my breast and my stomach -- I think you've got junkies and you've got junkies, if you want to put it in a term. Because you've got some got some real down and out junkies who do inject - they use anything, they don't care, you know. And you've got people that use because they've got a habit and although they've got a habit, they don't want to be in that situation and they try to better themselves even though they've the problem. And I think I'd put myself in the second category. I like to keep the kids and that tidy. I think you've got to maintain respect for yourself and the children.'

(011:10-11)

It was not only the opiate-dependent respondents who worked hard to distinguish themselves from the category of 'junkie' and thus the imputation of 'evil mother'. Alcohol-dependent mothers also found their status problematic, since their use of alcohol, as with opiates, threatened to fracture the fragile category of 'good mother'. Geraldine, a middle-class wife and mother, felt her status acutely:

'I feel really dirty and tainted because I use alcohol. -- It's seen as being like a tramp in the gutter, they think you've got to have nothing and nobody to be an alcoholic. -- I do think that it's really looked down on. -- that's what worries me - if anybody found out that I drink, round here, they'll probably think that I don't care about the children.' (035:17).

Thus, both the status of 'junkie' or 'alcoholic' challenged the respondents' legitimate inhabitation of the category 'good mother', and eroded their ability to exert control over their family life. This erosion of control was shown in several ways, for example by the attitudes of police and the attitudes of the respondents' own children. In one instance, Carrie (025b:7) described how, when she was arrested for a minor offence, the police threatened her with loss of custody of her children, telling her 'that I'm going to have my kids took off me because I'm scum because I'm a junkie'. In another instance, Beth was afraid that the status of 'junkie' would destroy her children's respect for her and damage their own self-image:

'I didn't want the children to lose that bit of respect for me, which I thought they would do if they thought I was just going round scoring off people and doing this and doing that. -- I just want them

to feel like other kids do. I don't want them to think, "Oh, our mum's a junkie. Our dad's a junkie. So that makes us different."

(011:3)

The impact of the women's substance-use on their children's lives is discussed in more detail in the following chapters. As well as contesting statuses such as 'alcoholic' or 'junkie', respondents were also actively engaged in other stigmatising activities such as stealing, fraud or prostitution, and again these presented barriers to their ability to immerse themselves in everyday family life.

Losing control and taking control: involvement in crime

The respondents' involvement in crime and their interactions with the police, their solicitors, and the criminal justice system were, for some of the women at least, a constant corollary to their childrearing activities, and provided a key theme in the narratives both of losing control and, in some situations, taking control.

Figure 10 shows the numbers of respondents involved in each type of crime.



Twelve respondents (25%) discussed their shoplifting during interviews, but twenty (42%) mentioned having been involved in shoplifting in the past or currently, making this the most prevalent criminal activity in this sample. In addition, ten (21%) discussed dealing drugs, seven (15%) discussed fraud (usually involving credit cards, cheque-books, or social security payment books), and six of the sample (13%) talked about being engaged in prostitution. In addition, two respondents had burgled, three had partners who burgled, one had worked in a gang demanding money off passers-by, and one had obtained her money for drugs by begging and busking.

Shoplifting

It is clear from the interview-data that some respondents felt very positive about their involvement in shoplifting. This attitude of confidence, enjoyment and expertise was expressed by six of the respondents.

For example, Annie at one time was going out shoplifting with a friend every weekday, stating enthusiastically, 'I love "shopping" -- I mean I really enjoy that. So we'd go "shopping" and then we'd come home and bloody drive round selling the stuff.' (003c:1) A year or so later, she looks back on that time and regrets the loss of income and the regular opportunity to get out of the house that the shoplifting provided:

'I was out earning not so long ago, doing shoplifting, like, and that was sound, cos I was out all day and we was getting money every day, but then I didn't see a lot of the kids or Jeremy -- but we had money all the time, whereas now we're both sat here with the kids,

neither of us go anywhere, we don't go out of a night or in the day.

The only place we go is bleeding CDT [Community Drug Team]'

(003d:15)

Stella found her skill a source of pride:

'That's just something I feel I can get away with. And I'm good at

it! I shouldn't say that but I am *good*! [smiling] I mean I could come

home *every* day with £300 worth of stuff. And I don't sell it. I keep

it. [smiling] You know, all these things here. I love ornaments.

Anything, bedspreads, curtains, shoes - never paid for a pair of

shoes, never. All the clothes that I wear ...' (004d:6)

From these accounts, shoplifting was not always linked straightforwardly to obtaining drugs. In the sub-sample of 30 respondents who completed the checklist, ten had never been involved in shoplifting, eight shoplifted primarily to raise money to pay for drugs or bills, and nine primarily to obtain household items for themselves, while two respondents shoplifted for both reasons. Altogether, around half of all the respondents interviewed had either regularly shoplifted in the past or were continuing to do so, and a large part of this shoplifting was not drug-driven but, according to the respondents, need-driven or driven by acquisitiveness, although it is not always appropriate to make a clear empirical distinction between shoplifting for 'drugs' or 'goods' as this quotation from Stella illustrates:

'I wouldn't be able to pay for all the heroin plus the food plus

clothing, so I pinch all the food, all the clothing, all the shoes. I pick

my [social security] money up on a Monday and I don't have to pay

none of it out, that's just heroin money' (004d:6)

For Mandy, her shoplifting career operated as a strategy for supporting and maintaining a 'normal family life'. Her account of shoplifting demonstrates both its ubiquity and its significance as a major community resource in some inner-city areas, where shoplifters and other criminals are very much part of a complex community network involving drug-users and non-drug-users, drug-dealers, neighbours, and local businesses:

'it was just things like cheese, coffee, things I couldn't afford, like paying the bills and everything, keeping the house running, keeping him [son] clothed. I used to just nick the dearer things on my food shopping so then we'd have the money for dearer things. -- you can go in with a shopping trolley like the old ladies use, fill it up, and you're making £90 in half-an-hour, so then I bought my carpets, I bought my telly, I bought my video, with the money that I made off all of that. -- it was just the place, everybody shoplifted. There was houses that you could go to, knock the door, and just sell everything. You'd have a door for each thing. -- They'd either sell it themselves, probably take it to work and sell it to workers and stuff like that. I could go into pubs, I could go in and sell blocks of cheese, bacon, for their rolls. I'm getting it cheaper for them, you see. Top class stuff, half price. -- it was like organised in [town], shoplifting. You'd have two geezers waiting just in case you did get stopped if you were having a big day out sort of thing. They used to do it in groups. You know what I did a couple of times, there was

four of us. I'd take the stuff, one was a decoy and there was two on the door, you know, things like that.' (041:5-6)

However, for some of the 'drug-driven' shoplifters, their involvement in shoplifting was a form of losing control, rather than taking control, as they found themselves involved in a scheme analogous to 'pimping', in which they carried out shoplifting under the control of a local thug, who might also be their dealer. Heather gives an account of this, which occurred shortly after she and her partner developed a heroin-addiction:

'We used to shoplift together every day -- I've been to prison for it three times for shoplifting to get money for heroin. -- Getting £2,000 worth of clothes and selling them for £400 to one person. -- The bloke who used to take us out, he knew exactly why we needed the money, so he used to come and pick us up every day, in his car, take us out. He weren't into drugs or anything but he knew "This is my way of making money. These idiots will go and rob loads of clothes, I'll give 'em peanuts for 'em and then I'll make loads of money on top when I sell 'em.'" (021:15,22)

Drug-dealing

This activity was mentioned by ten respondents, and presented a barrier to 'normal family life' in that it entailed strangers, often ones considered undesirable by the respondents, coming into the family home. This aspect is discussed in greater detail in the next chapter, on the impact of respondents' substance-use on their children.

As well as drug-dealing, heroin (but not apparently other drugs) fitted into users'

lives as an integral part of a complex barter-system, given in exchange for goods or services. This system tends to tie the user tightly into a social network and can be instrumental in the loss of autonomy and control, particularly if the heroin is given 'on tick' as payment for services yet to be rendered, as happened in the example above with Heather.

For other respondents, heroin-for-goods exchanges operated as a way of taking control, thus Patty and her partner Sean were involved in exchanging shoplifted alcohol for heroin, and Sean, who had a car, also earned heroin by driving people to and from a nearby city to buy heroin. This form of 'taxi service' was also mentioned by Carrie's partner Matthew and appears to be a common way of earning heroin among those with cars. Stella's account illustrates how heroin can operate almost as an alternative form of currency alongside money, in a tightly-knit social network of heroin-users:

'people knocking on the door saying, "Can you score me a bag?" and I'd say "How much do you want?" and if they says three, then I'd get one for nothing. -- when you're in the heroin scene, there's money everywhere. There's always a tenner to be made. Somebody'll say, "Here you are, I'll give you a tenner if you'll take me to blah blah, cos I need to." It was just so much money in the circle that you can't help but be buying heroin or being given heroin or - cos it's all heroin. You don't even have to have money in your pocket and you can still smoke it, cos it's - it's there.' (004f:9)

Fraud

Seven respondents discussed their use of fraud, involving benefit books, cheque-books and credit cards. Carrie was the most explicit in discussing the mechanics of cheating on benefit books, explaining how she would cash someone else's benefit book, keep half the money and give half the money to the rightful owner, who would then report the book as stolen and obtain a new book and thus the week's payment in full as well. Meanwhile, Carrie would be able to continue cashing the book until social security caught up with the book and put a stop on it at the post-office. Carrie explained how she would repeatedly re-use the same boxes to cash that week's payment several times over. She would put a type of glue, Cow-gum, over the box, then disguise the glue with talcum powder. After the post office had cashed the week's benefit and stamped the appropriate box, Carrie would rub off the glue with the stamp on it and be able to re-use the book to cash the same week's money again at several more post offices. Although she claimed to have done this only 'a couple of times', she stated that many people do this, since it is a quick and easy way of making money, if someone wants to 'make some extra cash' (025a:11).

Other forms of fraud, such as credit-card and cheque-book fraud, were less likely to be done on this *ad hoc* basis, because the cards and cheque-books had to be obtained first and, in this sample, this appeared to be done always by a male thief, who would then arrange with a female drug-user to go into shops and use the cards and cheque-books, dividing the money between the thief and the user.

Heather, who was involved in the shoplifting scheme mentioned above, had also been involved in a similar scheme for cheque-fraud:

‘Somebody that was dealing heroin was taking me out and giving me a load of heroin on tick. So every day I went out with them, him and his girlfriend, I’d do all the cheques and then I’d owe them all my money. So then the next day I’d have to go out because I needed more gear [heroin] that night. So I’d have to have it on tick because I’d paid them all my money for the day before. So I’d go back out the next day to pay for what I had last night.’ (021:23)

The degree of coercion involved in such a scheme varies, and Chris illustrates perhaps the most ‘freelance’ pattern, in which the initiative to commit the fraud appears much more clearly to be with her, but she still expresses dislike and worry at the activity:

‘People used to get [the cards and cheque-books] and I used to work them for other people. Like I’d have one page, they’d have one page, I’d have one, they’d have one -- [They shared it] Because I was the one that was doing it, I was the one that was actually going to the shop. -- some of [the cheque-books] come from in cars and you’re at a traffic jam or something. How people like open the passenger’s door and grab the handbags or smash the window and grab the handbag. Some like that. Some robberies. I don’t really ask, you know. -- I used to just go to the one guy. Just ask, because he had people would go to him and sell the books to him. So he would like come to me and - say he’s just paid £85, he’d get his money back straight away. So like he’d buy them and even put them up for me, for whenever I’m ready to do them. So it was quite

good. -- I hated doing it. I really really hated getting up and thinking oh, I've got to go and do this. Because it's a big worry. You think, oh I could get caught. And once the day's over it's like [sigh]. I'll probably go and get - I used to drink a lot.' (014a:13)

Anita was involved in a similar scheme of fraudulently using cheque-books and credit cards in return for heroin, and her account highlights to an extreme extent the degree of coercion and loss of autonomy in what was, for her, essentially little more than a slave relationship, in which a local thug and his girlfriend took over her home and used intimidation and violence to force her to comply with their demands, so that she was compelled to work for them every day:

'they chunked out [her partner] -- and they moved in, and the first few - at first they were being all nice to me, used to get me things, give me money for doing things - but once they moved in -- I had to do cheque-books for them every day and it was just horrible, nightmare it was with them. It was just too horrible to remember. And no-one dare come over to help me, cos I was alone, I didn't have no-one, I had Laura [one-year-old daughter], that was it. -- I managed to get away once -- me and my sister was coming out of the bedsit and see [the local thug] go past and stop, "Get in the car, now!". And my sister said, "Leave her alone." They said, "No, she's going to do some cheques for us." -- And once I had the gear off them, that was it, I was stuck with them again. "Now you owe us again". And it all started again. -- I couldn't work for anyone but them, he made that clear, because people used to say, "Could we

borrow her?" and he goes, "You only work for me." -- [Cashpoint cards and] cheque-books and credit-cards we'd also get, and I had to *know* to do the signature just like that -- And I pretended I couldn't do them any more, cos I was getting sick of doing it -- Sometimes I used to wish I got caught. Never did at all. And he'd have [his girlfriend] in the queue like a few feet down from me, so I wouldn't escape or pretend. -- they used to give me smack [heroin] just before I'd go in. -- I just took it as an everyday thing I had to do. It became like that. I had no choice, it was something I had to do.' (026b:2-5)

This pattern of, in a sense, being 'pimped' by a coercive thug to undertake criminal activities under duress, whether shoplifting or fraud, in payment for debts incurred through heroin-use, would appear to be fairly common, at least within the West Midlands area, but does not appear to have received widespread attention in the literature.

Prostitution

Six respondents talked about being involved in prostitution, and it was apparent from their accounts that there was a wide range of experiences, with prostitution taking its place as a barrier to women taking control or conversely being seen as a strategy for maintaining control and autonomy. Anita's account illustrates the pattern of prostitution constituting part of a wider dynamic of loss of autonomy. She was very hesitant to discuss her experiences, only talking about them in a coded, tangential manner, dropping hints which were not picked up on by the researcher at the time:

'Um, I just remembered bits I missed out while I was at that safe house. -- [I met a girl] and she told me she was working on the street, like prostitution, and all the money she earned and she wanted me to go down with her once just to keep her company. [pause] That was the first time I ever done that prostitution then, the guy wanted me or something, and it was easy money. I dunno why. -- I dunno, just done it I think one or two times. [pause] -- I don't know, there's some stuff in there ... -- [with a new partner] At the weekends he'd just want to go down the pub, take me with him, introduce me to his mates and all this lot, you know, just get me pissed. It was horrible with him [pause]. A middleman that just uses me. Another bloke that just used me for what he could get. -- I had to do things which I didn't really like at all. -- a lot of stuff was going on for me which I weren't happy about, getting used, and I'd been abused several times - I don't want to go into that, that's a part that -' (026b:6-7)

Here Anita changed the subject and never referred to this aspect of her life again in the interviews. Her account demonstrates the conceptual slippage between 'prostitution', 'sexual abuse' and a 'normal sexual relationship'. During another, untaped, conversation, this slippage was demonstrated even more starkly when Anita was asked if her current partner was raping her. She replied:

'I don't know, I don't know what rape is. Is it when they get you so out of it you can't refuse? Or when they tell you you want it really? Or when they tell you you enjoy it like that? Or when they

don't care what you feel? I don't know if it's rape or not, because I don't know what it's *supposed* to be like any more.'

Cathy's account similarly demonstrated this slippage between a 'client' and a 'friend', as she had only one, long-term, 'client' who gave her money or alcohol in return for sex, over many years. For her, however, this relationship was clearly defined as 'prostitution' and was part of a behaviour-pattern which disgusted her but over which she felt she had little control.

Deborah briefly used prostitution, earning large sums of money in a massage-parlour and escort agency, but she found her clients disgusting and perverted, and therefore chose not to continue despite the 'easy money'. She compared this way of making money to theft, and decided she preferred using theft:

'I seen the money [a friend] was raking in and I thought well assholes to this, living on £50 a week. -- [but] I didn't really like it anyway. I felt uncomfortable with it. It wasn't really me. Because like in previous years I've earned my money by stealing and shoplifting. That's how I've - and I've always felt comfortable with doing it that way. I've never had to solicit and lower myself. But sell me body kind of thing - although it brings in a lot more money and it's easier, less risk than there is pinching. But I don't know. Pinching's always been me, like that was my career kind of thing.'

(012a:13)

Later Deborah talked about her ex-partner wanting her to earn money for him, within a traditional gender-role relationship, and hints at the independence that employment as a prostitute briefly gave her:

‘I wouldn’t let him walk all over me. I’m not like most women who’ll fucking sit down and shut up, or go and wash the dishes when he tells me to wash the dishes. -- Or go and work in a massage parlour and fucking let him spend all the money on - he didn’t like it. -- he’d started working and what he wanted me to do was sit at home on me arse all day waiting for him to come in from work. I couldn’t go out nowhere. -- So I’ve sat here looking at four fucking walls wanting to kill myself.’ (012b:12-13)

It is interesting that, in this sample of 48 substance-users, of the six respondents who discussed using prostitution, four were opiate-users and the other two used recreational drugs or alcohol only. Nevertheless, the association of ‘hard drugs’ with prostitution remains, perhaps due in part to the imputation of ‘deviant sexuality’ to ‘outsiders’ as a technique of rejection and isolation (Douglas, 1992) and a form of status degradation (Garfinkel, 1956). This association was spontaneously mentioned, and rejected, by three opiate-using respondents, who had never used prostitution. For example, Bernice attributed the hostility of maternity hospital staff to the associations around drug-use, suggesting that they ‘think drugs are associated with prostitution and all that, I reckon, you know what I mean. They think like only really naughty people use drugs.’ (00B:5) Margaret found this association was prevalent also among male drug-users: ‘If you’re a female junkie and you don’t have a partner, other male junkies naturally presume

you're a prostitute because they think that's the only way you can earn the money.'

(005c:7)

Having investigated a range of barriers faced by the respondents in their quest to take control and maintain a 'normal family life', and having looked at some ways in which criminal activities could also be seen as enabling and supporting this quest, the final part of the discussion turns to the issue of emotional and practical support within the respondents' social networks.

Enabling control? Support from partners, the social network and professionals

As was seen earlier in the section on poverty and deprivation, respondents were unlikely, on the whole, to receive much support from their family networks. Again, the section on domestic violence indicated that many respondents were also unlikely to receive much support from their male partners. Nevertheless, despite these widespread experiences of violence, nineteen of the respondents did talk about their current partners as 'supportive' and, of those without partners, another two had previously had partners whom they considered supportive. Thus 21 of the 48 respondents (44%) currently or recently had partners they considered as in some sense supportive.

Two-thirds of the 'supportive' partners ($n = 14$, 29%) currently were or had been both substance-users, while only one-third ($n = 7$, 15%) were regarded as supportive and were not reported as substance-users. Of those currently with partners ($n = 28$), between fifteen and seventeen were using substances, giving a total of around 57% of partners who were substance-users. Of those currently

without partners (n = 20), nine (45%) had previously had partners who were substance-users, thus just over half of respondents currently or previously had partners who were substance-users. This is not an exact figure as it was not always possible to ascertain exactly what a partner was taking.

The expression 'supportive' is being used to describe partners who ranged from being considered the woman's 'best friend' to those who had perhaps a more neutral but certainly not damaging impact on the women's lives, in their opinion.

This includes seven partners who were both 'supportive' and, at least once, physically violent, thus a third of 'supportive' partners were also at times violent.

As well as this lack of a clear-cut distinction between 'supportiveness' and violent abuse, it has also been pointed out in the literature (Gossop et al, 1994:103) that women's greater likelihood of attachment to a substance-using partner means that they are 'simultaneously deprived of a protective factor and exposed to a high-risk factor' in terms of continuing with substance use and relapsing after treatment.

Turning to the respondents' wider social network, there was little evidence of supportive and enabling relationships here. To begin with, having some form of substance-dependency - either legal or illegal - as a large part of their lives tended to close users off from other people, because of issues of stigma and consequent secrecy in order to avoid discreditable disclosure. As Donna (008a:11) expressed it, in relation to her previous heroin-use: 'It changes you into - I don't know. Such a nasty person. -- It does make you into a real nasty horrible person. And you find you have to hang out with the other drug addicts because the normal people don't want to know you [laugh]. Which I suppose is fair enough.'

The finding that substance-users isolate themselves from the non-using world, and in turn consider themselves excluded by it, is consonant with previous studies (Rosenbaum, 1981a, 1981b; Taylor, 1993).

Respondents' support networks were also limited by the fact, as discussed in Chapter Five on the respondents' childhood, that there was a clear sense among the majority of the respondents that they did not find relationships with other women easy or congenial, and often preferred the company of men. However, a number of the respondents were or had been in long-term relationships with jealous male partners who explicitly discouraged friendships with other men. Thus women could easily find themselves isolated, with few if any close friends, either male or female. This is in contrast to Taylor's (1993:151) finding of a close-knit and apparently supportive network of women opiate-users in Glasgow, with 'strong relationships between the women and other drug users.' In this study, women were far more likely to say that, although they might know other women drug-users as acquaintances, they did not consider them as friends.

In contrast to the lack of informal friendship networks, and doubtless as a response to it, respondents talked about the relationships with professionals as an important aspect of their social networks. Thus, for example, Annie found her relationship with her drug-worker perhaps the most supportive relationship she had. When asked if she had any close friends she could talk to, she replied:

'No. The only people that I know now are users. There's a kid down the road -- I have a chat with him and I talk about me use with him but it's nothing, you know, nothing that I want to get off me chest, like, I couldn't talk to him about anything I didn't want

anybody else to know. You know. I don't talk confidentially or anything. You know, just comments on how things are and that, I don't talk to him as such. I don't talk to anybody really. -- I suppose [drug-worker] would be the only one that I could talk to, you know, *really* like, who isn't going to pass any judgement, and who isn't going to, you know, be - You know, like I get on very well with [the next-door neighbours, but if they knew she used heroin] that would be it. He wouldn't let his baby come round here again or anything like that. -- I'd never ever tell him about the heroin. I'd never tell him about that. I don't tell anybody.' (003b:6)

Similarly, Beth spoke about her drug-worker as the only person she could really talk with:

'I built up a very very strong relationship with [drug-worker]. -- And for the first time in all my life since I got raped by my brother-in-law I found somebody that I could talk to. Somebody I could - who wanted to listen to me. Who cared about what was happening to me.'(011:10)

It would seem that the more isolated women felt, the more their interactions with their drug-worker, probation officer, or prescribing doctor became a significant source of support for them (no respondent mentioned social workers in this context). For Deborah, who had recently moved and felt deeply isolated, her relationships with her probation officer and drug-worker were almost all she had to cling to. She said of her probation officer:

'I know that I can trust him with whatever I say. -- Usually I see him once a week but he's on a two week leave now at the moment and I miss him to be truthful. -- It's a twelve month [probation order]. So about December/January it's over. And I'll quite miss it. I'll miss the support, I will. I feel like going back to the judge and say "Make him do it for another twelve months", you know. -- [when the probation order is over] It'll hurt me feelings, I think. So, you know, I'll be careful not to get too attached, if you know what I mean.' (012a:11-12)

Not only did Deborah consider trying to extend her probation order, but she also continued unnecessarily on her methadone prescription simply in order to be able to continue staying in contact with her drug-worker. Obviously, this need of friendship with professionals varied between respondents, so that for example while Annie felt comfortable hugging her drug-worker, saying 'she's the only one who I can comfortably put me arm round because she does it to me' (003c:11), Carrie had the opposite response, regarding such hugging as a patronising and unwarrantable intrusion, exclaiming, 'they try and give you hugs and that and it's just totally false. You don't want that. You don't want a stranger giving you a hug!' ((25b:2).

This finding of the importance of professional support does not seem to have been mentioned previously in the drugs literature. However, it is similar - although probably overall not as marked - as a finding in a study of single parents (Evason, 1980:51) where a quarter of the sources of support cited by respondents were professional and voluntary workers such as 'doctors, social workers, health

visitors, samaritans and other members of self-help groups such as Gingerbread'. It is interesting that the substance-using sample, who were presumably more likely to be in touch with a range of professionals than the single parents in Evason's study, did not on the whole seem to find their professional contacts generally as supportive.

Summary

This section has explored several key facets of the everyday lives of the respondents. All of these facets - domestic violence and 'ambient violence', moving from home to home to refuge or hostel, prison, rehabilitation or detoxification centre, negotiating discreditable statuses such as 'not-mother' or 'junkie', and the varied ways of 'earning a living' and earning drugs - all contain within them the core problematic, for the respondents, of 'taking control', of negotiating and maintaining their own autonomy and continuing to protect and provide for their children as mothers building and maintaining a 'normal family life', within a context where their control and responsibility is continually challenged and undermined.

Whether the women felt able to effectively protect their children from violence, for example, or found themselves so powerless that their own small children instead felt obligated to protect them; whether they were able to deal with domestic violence and its consequences by themselves, or needed to rely on male protectors to ward off further attacks; whether they even felt safe in their own homes or were terrorised and driven out; whether they were able to be physically present to mother their children or whether they were separated from them; whether they could successfully stave off the status of 'dirty junkie'; whether they felt in control of their own bodies and sexuality or were unable any longer to define the

boundaries between affection and abuse; and finally whether their criminal activities were perceived by them as autonomous, fulfilling and enjoyable or whether such activities were curtailed by partners or controlled by coercive thugs - all of these are arenas where the issues of 'taking control' were daily in question for the respondents. As we have seen, many of the resources which may be available for other mothers living in poverty, such as access to wider kin support (Wilmott, 1987; Craig and Glendinning, 1990; Graham, 1992), or support from partners and friends or even professionals (Evason, 1980), seem to be less available to substance-using mothers.

In Chapter Three, we saw how research has tended to perceive women substance-users either as struggling conformers, using tranquillisers to minimise role strain for example (Cooperstock and Lennard, 1979; Helman, 1981), or as stigmatised outsiders, excluded from mainstream society by their deviant drug-use (Rosenbaum, 1981; Inciardi et al, 1993). This chapter, by placing substance-using women firmly within a more fully-realised social context, demonstrates clearly that neither of these two stereotypes adequately captures the complexity of their relationship to mainstream society. Rather, the women's commitment to attaining and maintaining a 'normal', everyday family life, and their resistance to being evicted from the category of normative or 'good' mother even by the imputations of being a 'junkie' or an 'alcoholic', simultaneously provide evidence that the respondents are indeed unable to conform fully to societal expectations, no matter how hard they struggle, but also that they work hard to remain, as much as they can, within a mainstream, non-deviant, lifestyle. They can thus be conceptualised, neither as 'struggling conformers' or 'stigmatised outsiders', but as 'reluctant non-

conformists' who indeed fail to conform to normative expectations of motherhood, but who do so reluctantly and who work hard to minimise and limit their levels of non-conformity.

As non-conformers, albeit reluctant, and maintaining their family lives within a context of often-fragile autonomy, how are women able to perform the everyday work of mothering competently? The next chapter will look in depth at the respondents' experiences of everyday mothering, given this background of contested autonomy and ongoing struggle to take control and lead a 'normal family life'.

Chapter Seven: Children and Mothering in Respondents' Lives

Introduction

Chapters Five and Six have explored, respectively, the childhood experiences which shaped the respondents' views on mothering, and the daily context within which, as mothers, they struggle to maintain a 'normal family life'. This chapter will now look in depth at what the respondents themselves thought about their mothering and about their children, and how they carried out certain key aspects of their mothering, such as choosing to conceal or disclose their drug-use to their children.

Few studies have examined in depth how substance-using mothers feel about their mothering. However, as discussed in Chapter Three, both Rosenbaum (1979, 1981a) and Colten (1982) investigated this issue in the United States. Rosenbaum found that the opiate-using mothers in her sample 'seemed to have accepted social and cultural role prescriptions and saw motherhood as central to their identity and purpose' (1981a:93), and that, unlike fathers, mothers accepted the responsibilities of childrearing, feeling that 'motherhood is their singular claim to worthiness, and it is often their greatest responsibility' (Rosenbaum, 1979:441).

Colten (1982) supports Rosenbaum's findings on the centrality of the mothering role for drug-using women, and she concluded:

'Addicted and non-addicted mothers do not differ in their feelings towards and perceptions of their own children, nor in most of the activities they engage in with their children. Heroin addicted mothers express more doubts about their adequacy as mothers and

their ability to control or influence their children. Concerns about maternal adequacy pervade their responses.' (Colten, 1982:77)

More recently, Taylor (1993:122), in Scotland, also concluded: 'Most drug using mothers ... like other mothers, attempt to do the best for their children. ... The women saw motherhood as an important function ... [they] adhered to the tradition that mothering should be their responsibility and totally fulfilling'.

Did the mothers in this study also conform to traditional notions of motherhood?

This question will be explored throughout this chapter, looking firstly at the impact of children on the respondents' lives, and secondly at the impact of the respondents' substance-use on their family lives and their relationships with their children. The following chapter continues the discussion, by exploring the ways in which the respondents adhered to traditional notions of being a 'good wife and mother' and the dimensions which they perceived as constituting good mothering.

Impact of children on respondents' lives: issues of gender

By far the most common view among the respondents was that their children generally had had a positive impact on their lives, often a calming and stabilising influence, motivating them to stay away from criminal activities and drug-taking.

As Bernice commented, 'I thought she'd calm me down a lot and she has, a lot, know what I mean, otherwise I'd reckon I'd be back in and out of prison by now, if it weren't for her' (00B:2). Chris expressed a similar view:

'I have no intentions of committing any other offences because of [her child]. -- If it wasn't for this child I've had now I'd probably be dead. Because he's stopped me in my tracks. I thought, well just

stop and take a look at your life. He comes first before anything else now.' (014:4,8).

Children also provided a focus for their lives, thus Clare remarked, to the question of what helped her cope, 'Just having them. Having the kids around. Gives me to think twice about taking drugs.' (00C:12). For Annie, Amanda and Jane, the thought of their children had held them back from suicide. As Amanda stated bleakly, 'it's the children that keep me going -- it's because of the children that I'm alive. -- I want to die but what would the kids think then.' (034:1,3).

Other women spoke of the positive pleasure of having their children around. Stella, reunited with her children after they had lived with their father, commented how, 'I just feel complete again now' (004f: 9), and Penny candidly admitted, 'I enjoy them being at home when I don't send them to school. -- It's company I think as well' (023:22).

Thus, in general terms, children were seen as giving the respondents a stabilising influence, a focus for their lives, and enjoyment of their company. These positive influences, however, appeared from this study to be affected by the gender of the children. There were some intriguing hints in the data about the differential impact on the women of mothering girls and boys. Of the six respondents who were clearly having a difficult relationship with a child, five were having problems with a daughter and only one (Heather) with a son, while of the nine respondents who talked about their child as a support, two (Bernice and Elaine) talked about their pre-school daughters as having calmed them down and kept them out of trouble, while the other seven tended to view their son (usually their eldest or only son) as supportive in a much more 'adult' sense, as someone who becomes for them

almost the sensible, mature, non-drug-using partner that their actual adult, drug-using, partner is not capable of being.

Thus Heather, the only woman having significant problems with a son, is also classified as finding her eight-year-old son supportive, in the sense that he has taken on some of the adult responsibility of trying to keep his mother off drugs:

‘Malcolm is really streetwise and even though I’ve never done drugs in front of Malcolm he knows, you know, he knows when I’ve took drugs. He’ll say, “Mummy, you’ve had some of that stuff.” He’s so wise. And like, I feel - say like he’s been really naughty -- I’ll send him to bed and then I think to myself, well it’s your fault he’s like that you know. If you hadn’t have took drugs maybe he wouldn’t be like that. So then I’ve let him down because I feel that it’s my fault that he’s like that. -- [Malcolm misbehaved every day] and when I used to question and say “Malcolm, why do you do this, darling?” he used to say, “When you stop taking that stuff I’ll stop doing this.” -- he’s seen a new bike he liked and it was £80 and I tried to explain, “We haven’t got that sort of money, Malcolm.” “Yeah, but you’ve *spent* that sort of money, haven’t you!”. -- Malcolm’s dead grown up anyway and he knows what’s going on, he’s not stupid. -- [He says] “You always promise, you always promise you’re going to get off it and you don’t.” -- He’s only eight but he’ll sort of - when I try and speak to him about things now, he’ll just say, “Mummy, I don’t want to listen. I don’t want to listen. You promise all the time and you break your

promises and I don't want to listen until you start, you know, keeping your promises and I don't want to listen to it." He sounds like an adult.' (021a:7-9, 021c:10)

Patricia readily admitted that 'I prefer boys' (006c:10). She had two older girls but looked to her eight-year-old son as her supportive 'little man':

'He does everything for me and, you know, he's a lovely little boy. -
- the main man in my life you see, my little boy. You know, I wanted a little boy. You know, you've not met any child like Peter.
-- Well, he just knows how I feel about everything. My little man, aren't you, Peter? [child is in room listening and agrees]. -- It's just the way he is. I can't trust the girls. If you send the girls to the shop, they won't buy or get what they're supposed to. It will be wrong. If you send Peter it will be great.' (006b: 3,9,11)

This attitude of looking to her son - again eight years old - for a level of support usually provided by an adult was again shared by Stella, who explicitly contrasted her son Derek with her partner, Philip:

'Derek's really good you know - he's more like my partner than what Philip is. Philip's like my little boy, "Where's my socks? Have I got any jeans? Have I got this?'. Now Derek has got a wardrobe in his bedroom with his shirts and jumpers and trousers. He'll go automatically into his cupboard and dress himself, where Philip will get up and he'll go "Have I got a shirt? Have I got this? Have I got that?'. I don't understand because like he knows where his clothes

are, but he'd rather sit there with nothing on and go to me "Where's my clothes?" and that really bugs me, because before he's even got out of bed I've vacuumed and polished and tidied up -- Philip gets up, straight away I've got to look for jeans and jumper and run his bath -- Derek's really good. He'll go in the kitchen and if he's thirsty, he'll make himself a squash and do some bread and cheese, but *he* [Philip] won't, he'll go "Can I have a cold drink? Can I have a sandwich?" (004e:1)

Stella also related an anecdote in which, as with Heather and her son, her eight-year-old son took responsibility for discouraging her heroin-use. Having seen Stella previously using foil to smoke heroin, Stella explained how:

'he says 'Don't do that' cos he knows, sort of thing -- I was cooking in the kitchen and there was some foil, and he's gone "I told you not to even have a tiny tiny bit" and I've gone "Derek, look in the oven." Right, there was meat in this foil and I've gone "*That's* what the foil's for, really". He thinks foil is just for smoke, he's never seen what it's really used for and like, it made him think a bit. He's gone, "Ahh". But he didn't - he was upset when he seen the foil out. -- Soon as we moved in [to the new house], he's gone "That's it now. No more brown [ie. heroin]." (004d:4)

Many months later, Stella related a similar anecdote:

'He really looks out for me, Sarah, like the other day, right, I was cooking chicken and like he heard me with the foil. Straight away

he's like - [looking hard at her] and I'm laughing at him, going "Oh, I caught you, Derek!" He's going "I'm looking at you, as well". I like it, I do. I love it.' (004f:9)

As well as behaving in a mature, almost adult role, and discouraging their mothers' drug-use, sons might also be expected to protect their mothers physically. For example, as noted earlier, Clare accepts that her eldest child, a boy of seven, feels responsible for her physical safety, commenting of her son's attitude to repeated incidents of domestic violence, 'It's always at the back of his mind that it could happen again .. and if he's not around he feels that he can't help.' (00C:12).

Barbara appeared to be the only respondent, interestingly, who spoke about an adult child as emotionally supportive, and it was clear that her son had helped her through her periods of alcoholism and motivated her successfully to seek help: 'I was completely dependent on my son. He was paying the bills. Doing everything -- I felt I wasn't capable of coping with my own life -- Even for shopping, everything like that my son did.' (027b:6). Two other respondents talked about their adult sons helping them financially (Bernadette) and by protecting them from violence from neighbours and her partner (Beth). No adult daughters were mentioned in the interviews as particularly supportive.

Thus, out of the total sample of 48 respondents, four spoke about their sons aged seven or eight as supportive in an almost adult sense, whereas no daughters were referred to in this way. In fact, where the behaviour of daughters older than pre-school was singled out for particular discussion, it was exclusively presented as something problematic so that, for example, Marlene, not in an interview context, accused her eleven-year-old daughter of driving her to drink and drugs by her

behaviour, and Patricia, who was so full of praise for her son, had almost nothing but criticism for her daughters, aged eleven and ten.

Annie had one daughter, aged thirteen at the beginning of the interview series and fifteen (and a mother herself) by the completion of all interviews. For Annie, the behaviour of her daughter was identified as the biggest problem she faced, and concerns over her daughter ran like a thread through all the interviews with her.

Annie explained:

‘When I had Angela I was just too young, you know. Too immature to have her and I don’t think that we had that - I don’t think that bond ever come. You know, sort of - if anybody else touched her then I would be *there* and I would defend her to the hilt. -- But at the same time I know it isn’t 100 per cent with us. -- with the lads it comes natural. Like - and Duncan, with the baby Duncan, he doesn’t need to ask me for anything because I *know* with him. But I don’t know [with Angela] - it just doesn’t come to me. -- I don’t know whether it’s because she’s a girl and I don’t want her to be a *div*, you know, I don’t want her to be taken for granted by anybody, you know. I’d hate that. -- I hate the thought of her being bullied. I mean she was only six or seven or something, at school, probably about eight, and this girl kept bloody picking on her. So I went to the school and I made her have a fight with the girl while I was watching her, and she battered her! -- Whereas if that would have happened to the lads I don’t know what I would have done. I wouldn’t have done - I fucking *certainly* wouldn’t have done that.

But I felt that that was the only thing to do. That is what I thought was the best thing to do. But looking back, no way, that's not fucking nice. -- I wanted her to be strong. I didn't want anybody to take her for a prat or bully her, like.' (003c:9, 12)

Annie herself also fought physically with her daughter but not her sons. Speaking about herself as a young woman, Annie talked about herself as a 'div' and a 'prat' for allowing herself to be beaten up and 'bullied' by violent partners and it seems clear from what she says that, by attempting to make her daughter 'strong', Annie is trying to protect Angela from the abusive experiences she herself endured as a young woman.

A similar motive seems to underlie Beverley's troubled relationship with her daughter, who at the final interview was aged eighteen and herself the mother of two. At around thirteen:

'she was getting into trouble beating people up, she just went through a mad phase. But she always said that she'd seen me [being badly beaten up by partners], she thought, "Well *no-one's* going to do anything to me!" She just wouldn't let no-one touch her. -- because she was pregnant I had to like try and control her -- If she got into fights I would threaten her in a way that would - "If I find out you've been fighting today, I'm going to hit you when you come home. And believe me, I don't care how pregnant you are, I'm going to hit you.'" (001a:6)

Thus the motivation behind Beverley's violent relationship with her daughter seems again to be based paradoxically on her sense of protective care towards her.

Powerless responsibility: sexual abuse among respondents' own children

Beverley also spoke about her fierce desire to protect her daughter from going through the trauma of sexual abuse which she herself had suffered, stating:

'I'd think, "My life's never going to be like that, if I ever have kids, any man that touches my kids I swear I'll fucking kill them." -- And nobody - I always thought nobody would ever touch her. And for most of her life, when she got into fights and that, I always was out there fighting for her, getting myself into trouble.' (001b:2)

Her protection had failed, however, and Beverley had found out recently that in fact her daughter had been sexually abused as a child, when Beverley had been forced to leave her to escape from her literally murderous husband. Beverley now has to come to terms with the guilt arising from the almost inevitable failure of attempting to take responsibility and offer protection in a context where she herself was without power or resources.

Similarly, Joyce had escaped from a very violent partner, leaving their children behind in the care of her partner's family. Again, she had discovered years later that her daughter Isabelle had been sexually abused. At one point she had visited the children and found that they were being physically beaten:

'and I just grabbed them up and I got into the car and I took them to the police station. They said they couldn't do anything. And where I was living and the life I was living I couldn't take them with

me. But I should have. It was wrong. I took them back. He put them into care. Like Isabelle blames me for that, too. I didn't put her into care but I wasn't there. So I got the blame. It's one of the things she holds against me.' (017:9)

At least two other respondents, as well as Beverley and Joyce, had also found out, or suspected, their children had been sexually abused while in the care of others. For Meg, her son had been sexually abused while in the care of another, and for Anita, she suspected her daughter had been sexually abused by her baby-sitter. For both women, caught in a cycle of violent and abusive relationships themselves, their own lack of power and autonomy frustrated their efforts to protect their children and moreover, their low status within the 'hierarchy of credibility' (Becker, 1967:241) makes it hard for some women to be heard when they do try to summon help. As Anita recalled, when her baby daughter was in hospital:

'every time I put her in the cot she started crying, and she would go to the end of the cot and lie there with her legs sticking in the air. I thought, "That ain't right." But nobody else seemed to notice this. And I was going to the nurses, "This ain't - something's wrong with her" and they just said to [her companion] "Take the mother away, she's just upsetting things. Laura's quiet now." But I could still hear her crying when I walked down the end of the corridor. But nobody would take notice.' (026b:8)

Anita then recalled another incident that had occurred sometime later:

‘Somebody’s abusing her, or something’s wrong, because there was a time when Jonathan had gone to work and I was still lying there and Laura come in, thinking I was asleep, and started doing things to me. I don’t want to go on about that.’ (026b:8)

Remembering this incident, Anita was so disturbed that the interview was terminated at this point. However, Anita’s concerns were not only disregarded by professionals, but actually used as a reason why Laura could not return to Anita’s care. The Guardian Ad Litem report on Laura, a copy of which was given to me by Anita, used Anita’s concerns as evidence of significant harm justifying Laura not being in her mother’s care. As the report stated:

‘There are clear suggestions -- that [Laura] has been harmed by some of her mother’s behaviour. The allegation that she might have been sexually abused came originally from Anita -- These allegations have never been substantiated -- Anita’s fears arise perhaps from her own reported experience of sexual abuse as a child and may have no firmer foundation than this. Even if they are completely unfounded, they have exposed Laura to an unpleasant medical examination and as long as these doubts remained in Anita’s mind, would presumably continue to do so if Laura returned to her mother’s care.’

Overall, therefore, the data offer tentative suggestions that sons are more likely to be regarded as supportive and almost as a responsible non-drug-using replacement

partner, while girls are likely to be involved in a far more problematic relationship with their mothers, possibly because the women see elements of their own vulnerable and abused selves in their daughters, and thus try to toughen up their daughters to protect them from abuse - an effort which in fact is in itself abusive and which still cannot protect their daughters from further harm.

This gendered dimension of the parenting relationship does not seem to have been noted previously in the literature on substance-using parents, but may conceivably have a bearing on the likelihood of women being able to give up their substance-use. Those who perceive themselves as having a supportive son may be more able to take control over their lives and stabilise or reduce their substance-use, rather than those who perceive themselves as having a difficult daughter who inspires in them complex and painful emotions of powerless responsibility and frustrated - even counter-productive - protectiveness.

Impact of substance-use on mother-child relationship

Having looked at how their children affected the respondents' lives, this section explores how their substance-use affected their relationships with their children.

The section is divided into three, moving from a discussion of the general impact substance-use had on daily family-life, to the impact of correlates of substance-use such as drug-dealing and other crime and its effects on the children, and finally to the respondents' hopes and fears for their children in the future.

General impact

The mothers discussed the impact their substance-use had on their children, pointing out both its benefits as well as its disadvantages. The discussion of the

perceived benefits of substance-use is found in Chapter Ten, which analyses the functions substances play in women's lives. Benefits were seen as relating to the use of a wide range of substances, including opiates, amphetamine, alcohol and cannabis. Disadvantages were seen as relating almost exclusively to heroin or alcohol. Thus, of the eleven respondents who had a significant problem with alcohol, seven spoke about how their alcohol-use had negatively affected their children.

For three respondents, Lisa, Amanda and Cathy, their drinking had led to their children being freed for adoption. For example, throughout her pregnancy, Lisa had used not only alcohol but also high levels of benzodiazepines and various codeine-based medicines. Social services concerns led to her baby being made a ward of court straight after birth, then eventually freed for adoption:

‘[the morning after the birth] there was a message left for me that a certain person, I can't remember the name, social services, wanted to see me, see us. And then they told us that he was being made a ward of court -- I was sat there in shock. I felt as though it was all going wrong around me and I'd got no say in the matter. As though, I mean, it wasn't even my baby. -- [she regained custody of her baby when he was five months old]. And again I'd had some tablets, sleeping tablets, and I didn't know that I'd done it but [my sister] told me that I was getting him changed and he was crying, he was wriggling about and wouldn't keep still, so I shouted at him and gave him a good slap across the face. -- That's when they brought in social services again. -- I was waiting for him to come

back in the afternoon, the door went as I was making the jelly for him for his tea, and these two men come, two social workers came in and said that he's been put in foster care again. -- And it all went downhill from there. I mean it absolutely broke my heart. Which was then adding to the vicious circle. I was taking more and more tablets and medicine and alcohol.' (009:11,15)

Amanda described her initial contact with social services:

'I was coping with the children. I was okay. It was the other members of the family that were making themselves at home in my home that made it very difficult for me. And so the drinking got worse and now my two youngest have been granted a freeing order for adoption. They never looked into the problem. They didn't say, "Why do you drink? What makes you this way?" The only thing they said was, "We've got to remove the children because it isn't good for them." -- They didn't like me being an alcoholic mother.' (034:2-4)

Amanda had had her first contact with social services after she had been seen publicly drunk. In Cathy's case, other mothers had smelt drink on her at school:

'I started drinking secretly on my own in the day. I started hiding cans, that sort of thing. -- The drinking just got worse in the day. -- it was when Lorna was born I did get a visit from a social worker saying some of the mums at school had smelt drink on me and that. -- The most thing I feel guilty about now is the kids, now. I could have done everything better for them. I could have given them a much better life and that, really. -- the first time that she [daughter]

did show that she was distressed by my drinking was when her best friend was going to come to the house to stop and I got so drunk that I couldn't look after her and that. And she did say to me, she said, "Please don't drink in front of my friends, Mummy." That did stop me for about two weeks.' (037:19,20)

Meg's drinking had also attracted social services intervention for her children, as she described, 'I started drinking basically all day. I took the children to nursery drunk, and social services were called in. -- I couldn't stand up. I had to have a can of lager and a fag in the morning before I could get up -- then I'd probably have another two before I took them to nursery. -- And I went to pick them up from nursery and I was drunk and social services called and took them into foster care. - - I wasn't capable of looking after them.' (028a:12-13)

For the other mothers who used alcohol, the effects had been much less extreme, but gave the mothers a pervasive sense of worry and failure. As Barbara expressed it with regard to her adult children: 'I think they were both anxious about how I would behave. -- I mean I would like to see my grandchildren more often but I think my son's very ... I have to wait until I'm asked. -- when I'm in his house it's almost as if I'm being watched.' (033:7)

Sandra drank up to a litre of sherry every day, drinking it secretly in the evenings after her chores, to deal with her feelings as her children grew older and she faced the prospect of an 'empty nest' alone with her husband. She felt the main effect of alcohol was to isolate her from her family and make her unpredictable and irritable: 'it interfered with my home life because I was not in control of myself. -- I mean a home life, you've got to be in control of your own sort of emotions -- I'd snap at

them' (029:12)

Geraldine tried not let her drinking affect her children at all, but worried that they suffered nevertheless. In fact, Geraldine explicitly linked her alcohol-use to her mothering ideals, feeling that if she had been more 'selfish' she might not have developed an alcohol problem:

'If anybody found out that, like, I drink, round here, they'll probably think that I don't care about the children. Which is completely - it's the opposite. I've probably ended up with some of the problems I've got because I've tried too hard and cared too much. If I'd sort of been a bit more selfish and took myself out one night a week or one day a week or something, and had a break, I probably wouldn't have been so stressed out -- [I: So really it's also about being the perfect mum?] Yeah. I mean you've just hit the nail on the head. I wouldn't take them anywhere without them being immaculate. They had to behave immaculate. -- It's this thing that you want to be a perfect mum really, yeah. I'm not so bad now. -- It's really hard when you're trying to give everybody - I think that's probably what, when I took that first overdose it was I had nothing left to give. I just was totally drained. There wasn't a bit of me - I just didn't have anything left I could give to anyone.' (035:17-18)

For those respondents whose primary substance of use was opiates, there was a range of issues which the women identified as having a negative impact on their childrearing. For example, Heather highlighted the legal, emotional and financial costs of heroin-dependency:

'I decided that I'm not going to go shoplifting to buy drugs any more. Because if I go and get caught then my mum will have to have my son and it's just not on. Cos even though Malcolm hasn't seen any drugtaking he knows exactly what's going on. -- Like he'll say, "Can we go to the pictures, Mum?" and I'll say, "No, Malcolm, because we haven't got any money today." And he'll say, "But if you didn't spend all your money on drugs then we'd be able to go."' (021a:25)

Donna emphasised the physical effects as well as the financial drain:

'It makes you lazy as well. You just want to sit there, you can't be bothered to do this, that and the other. I can't be doing with that. And the kids do suffer. Well, if you've spent all the money, come dinner-time you've got to make a dinner out of what? Nothing. And that's not fair. And clothes-wise, and going out, that's not fair either. You know, because you haven't got the money to buy them the clothes they need.' (008a:11)

Adele, too, talked about the physical effects of heroin-use and how it affected her ability to care for a five-month-old baby, particularly because she was likely to experience opiate-withdrawals on waking in the night:

'it's horrible at night with Billy and if he doesn't sleep through the night you have to try and wake up too, like twice each evening with him. Sometimes you just want him to go back to sleep cos I just want to sleep, I'm so tired. Sometimes when I wake up at night it's

like I withdraw straight away, not really bad withdrawals but I feel yucky, and I just want him to go back to sleep, and he's worth more than that, really, isn't he. -- I don't think it's good enough. I think Billy's worth a lot more than what I'm doing at the moment. He needs a lot more time and patience.' (00A:1,6).

Annie and Beth both agonised over the impact of their opiate-use on their children. Annie wondered whether her example would lead to her children later turning to drugs, and for Beth, this worry had become a stark reality, since her eldest son had become registered as a heroin addict. Other respondents, also, struggled with the issue of whether allowing their children to know about their substance-use was harmful to them or not, and what steps they should take to protect their children from knowledge about substance-use.

In this sample, Stella appeared alone in discussing her drug-use openly with her children, perhaps partly because she was also one of the most confident mothers in her belief that she was able to make things right for her children:

'I feel that the more she knows, the more likely she is *not* to follow in my footsteps, as well. [Daughter once saw her smoking heroin] She's come up to the bedroom and caught me, but I haven't ... like, scuffled it away. I need her to - as soon as she's seen it, I've gone, "This is heroin, and this is what it's doing to me, and I'm trying and -". She basically knows, basically. I wouldn't sit there and smoke it in front of her, but it was because she caught me and she needed to know. [Her younger son] He's actually seen me doing it. I've done it in front of him. -- As far as I'm concerned, what he knows is

good for him, very good ... Even though his mind shouldn't even be ... involved around it at all, but if I am and it means he is, then like he needs to understand, you know, he's got to know it's wrong and he does know it's wrong... But, you know, in a couple of years it might have been totally forgotten, on his part. It's not as if I'm scarring him with anything... I don't feel that I have. I hope I'm not. But even if it is scarring him, I will mend that. I know I will mend that. -- this badness will end in right.' (004d:4-5)

Patricia expressed the more representative view, which was that her children knew nothing about her drug-use other than that she and her partner used 'medicine', even though they 'know if the kitchen door's shut they've got to knock on the door and then they'll get in trouble if they walk in there without knocking on the door, which they do' (006c:9), and her children had seen her and her partner injecting, and had seen methadone bottles and injectable ampoules 'all over the place! [laugh]' (006c:9). She explained that, if her children asked about her and her partner's use of methadone, she would reply:

'Medicine. Simple as that. Just medicine. I think they have been told before it's just medicine, trying to make out it's not *bad* what we're doing, because .. cos it *is*, you know what I mean, it's like a diabetic has to take drugs every day -- let's hope they've got more sense than to take drugs and smoke and drink and whatever, hopefully they will, you know, I can't do much more than that, can I. -- I think they should have learnt by my and [husband's] mistakes, really' (006c:10)

Carrie shared this view, although with both Carrie and Patricia it seemed unlikely that their children were really quite as naive as was supposed. In both cases, their small children were allowed to play with the empty methadone bottles and used ampoules, and, in Carrie's case, the drug-dealing from her house made it implausible that her older children knew nothing of her lifestyle, despite her assertion that, 'I always make sure that the kids, my kids don't know nothing about it. They don't see anything of it. They don't hear. They don't see pipes [for smoking crack-cocaine]. They don't see needles. They don't see anything. They don't know nothing about it.' (025b:23)

Another identified disadvantage of using substances as part of one's everyday life, as well as the possible risk of children using in future, was children disclosing to others. This was one of Annie's great fears:

'Imagine them playing doctors or something at school, you know, and they got out the fucking syringes! -- it does worry me at school -- the teacher saying to them, or a copper coming in and saying, "If you know anyone that sells, or who does this, put your hand up", and I could imagine Duncan going, "Ooh yeah! Me Mum does that!" You know, you always get that sort of horror. -- I do dread, I do dread that sort of thing coming up' (003d:8)

Once substance-use was known about, the knowledge could prove damaging and hurtful for their children. For example, off the tape, Marlene related a painful incident that had occurred with her neighbour, who had shouted at her in public with her children nearby, and called her 'a drugged-up drunkard'. Cathy related an incident at school: 'it ended up with some girls and they circled her and was saying

that Mummy's an alcoholic and all that stuff. It made her cry and all that. That made me feel really bad. -- since then she's changed schools' (037:21). It was not only outsiders who could inflict pain through such disclosure, however, and Alison told how her partner jeered at her in front of her children:

'when we have a row he always brings it up and throws it into me face, "Well, are you going to go down and get some drugs, now, are you?" [jeeringly]. You know, and all this. And he says it in front of the kids, which is not very nice, you know what I mean, for a five or six-year-old sitting there listening to this - saying about his mum being on drugs.' (020:14)

Children aware of drug-dealing

As long as substance-using remained a private, secretive activity, the risk of such disclosures, and possible public shaming, was minimised. However, as noted above, public drunkenness carried the risk of outside intervention, and so did drug-dealing, in the form of arrest and public prosecution. Drug-dealing and its impact on mothering was discussed by Annie, Carrie, Mandy, and Stella, and in the main it appeared, as far as possible, to be kept well away from the children, to avoid inadvertent disclosure as well as to protect the children.

The main drawback of drug-dealing, apart from the (apparently small) risk of being 'busted' by the police, would seem to be the constant flow of visitors to the house. Only one respondent, Mandy, talked about a drugs bust which had taken place while her child was in the house, and claimed her child was not particularly frightened by the event, and also that the police later apologised in court for their

heavy-handed approach. She also felt that, because she had a very lively social life, the number of visitors when she was dealing was not greatly increased.

Carrie and Stella, however, had reservations about the volume of people passing through their house, the interruptions to their private home-life, and the lack of control over separating their household from undesirable visitors. Drug-dealing from one's home breaks down the public/private division, making one's personal private space into a public trading arena, where visitors can call at any hour of the day or night, walking in from the front door usually into the kitchen where trading (and use) takes place. Thus, for example in Carrie's house, the visitors constantly walked through the front room and past the television where the rest of the family sat trying to relax. Carrie resented people she did not like becoming involved in her family life in this way, and Stella lamented, 'it's just hassle. This [constant interruptions] is the sort of thing that happens when you're having involvement with drugs. People know, and hear about it, and come here. -- we want to live a bit more on our own, and more personal.' (004b:1,12)

The distinction between public and private arenas is a key concept in understanding family life and 'the home' (Davidoff et al, 1976; Ross, 1979; Eisenstein, 1984; Allan, 1989; Crow, 1989; Allan and Crow, 1990; Edwards, 1993; Ribbens, 1994) and the inability to maintain family privacy against at times undesirable and unwelcome customers is likely to be of significance in mothers' and children's experience of drug-dealing from home.

Children aware of shoplifting

Turning to another aspect of the respondents' lifestyles, three respondents, Annie, Deborah, and Mandy, also discussed their children's knowledge of their shoplifting and their attitude to their children themselves shoplifting in future. Annie, a very regular shoplifter, described herself as 'I'm not dishonest, I just enjoy shops!' (003b:3). She admitted, 'I do do it with the kids sometimes. If I have to take them with me, then I will. Honestly. Being honest about it.' (003c:2) Although her children knew about her activities, and sometimes her youngest embarrassed her by shouting out 'Are you going to nick that?' or 'Ain't you paying for that?' as she left the shop, she felt 'I don't think they're aware that I go out as often as what I do' (003c:3) because she generally shoplifted during school-hours. Her view regarding her own children shoplifting in the future was:

'I would rather them shoplift for money than take it off a person or go burgling or anything like that. If they're going to be desperate for money then that is the way I would rather them earn it, to be honest. If you're going to be a criminal then I can't see anything wrong with - obviously it's wrong, you know, because - but, you know, it's the, uh - it's just easy money, really.' (003c:2)

Annie's straightforward attitude did not appear to be shared by the other two respondents who discussed shoplifting and their children. They both generally expressed ambivalence about shoplifting, taking pride in their own skill but hoping their own children would not follow suit. For example, Deborah stated, 'I want to be normal really, and I don't want kids growing up knowing their mum goes out lifting. And I'd never do it so Agnes could see.' (012a:16-17). Mandy, when asked

how she would feel if her son began shoplifting, replied:

‘That a hard one, innit. Cos when *you* do it -- I would be angry at him doing it. I would. Because I teach him not to touch things that aren’t his. -- I hope I’d be understanding with him as well -- you don’t want your kids to do wrong, do you, you want your kids to do better than what you’ve done. That’s the whole idea of it all.’
(041:7)

Mandy, in this quotation, expresses one of the central difficulties for the respondents as mothers living a criminal lifestyle. She recognises that she is asking her children to ‘do as I say, not as I do’, and this paradox of the mother attempting *not* to be a role model for her children, while still taking responsibility for teaching them her moral values, was implicit in much of the respondents’ conversations. It was particularly salient in the discussions on the respondents attitude to their children’s future substance-use.

Fears for their children in the future

As with shoplifting, respondents were concerned that their children might follow in their footsteps. Cathy was therefore pleased that her daughter specifically wanted not to be like her:

‘I did explain to her how important it was that she does not become like Mummy, you know, with the drinking and that. And I do think that now she realises and that, she knows it’s not normal and that. -- But she often did say, “I’m not going to drink like my mother does.”’ (037:21)

Sandra also was explicit about not being a role model for her children, yet teaching them her moral code:

'I think because they've seen what it's done to me they are very very careful. Very careful indeed. So I don't worry about them. We talk about it now and they - like I said to them, "Don't follow my example, don't do as I do. Do as I tell you." And they accept that. They accept the fact that too much drink is not a good thing.'

(029:7-8)

Hilary felt she would be happy to take on a more educational role with her child if she did choose to use drugs, but at the same time was aware of the constraints on her ability to guide her, since she felt it would be hypocritical to ban her from using drugs altogether. As she explained:

'if Mary-Beth wants to take Ecstasy or smoke draw I can't say anything because I've done it myself. But I will talk to her. I'll advise her and if she wants to take that advice she can take that advice. -- [If she started injecting speed] I think I'd batter the head off her, actually, to be honest. -- I'd sit her down and I'd tell her everything. I'd say "If you want to carry on, you carry on. Please don't do it in front of me. Not in my house. Go somewhere else and do it. Learn for yourself. I'm only telling you what's happened" -- I wouldn't - no, she could do anything else but that. [If she took Ecstasy or LSD] I wouldn't *like* it, but you know, I couldn't be a hypocrite now, could I. -- I wouldn't mind her smoking cannabis, because cannabis is nothing.' (022b:17-18)

When it came to opiates, respondents felt strongly that they did not want their children following in their footsteps. As Heather said, when asked how she would feel if she found her son was taking heroin when he was older: 'Oh God, I'd be heartbroken. Oh God, I'd be devastated. I'd feel it was all my fault.' (021c:11)

Stella was far more sanguine about her children not following her example:

'I also think and I hope - this is just me - that I may have done my kids a favour by being who I am and what I've done because I know that my daughter's also said to me, "I don't ever want to be like you, Mum" and she doesn't, and I know she won't and I also know my boys won't, so I think I might have done - in a bad, twisted way - have done my kids a favour -- if anybody's gonna take drugs it was gonna be [my daughter] but she won't now, I know she won't. She won't even smoke a cigarette.' (004f:4)

Several of the respondents pinned their hopes on drugs no longer being a 'novelty' to their children, but for Annie at least this had already proved a forlorn hope:

'I thought, well if they're brought up around it, it's not a novelty to them, so they won't wanna explore or - it'll be nothing to them, but I was fucking wrong then, cos Angela stole a quarter of me draw not so long ago. -- I thought she would never do that. I thought, you know, that - she's seen it all. If people ever come to her who was on about draw, she'd think, well I seen fucking much more than that, that don't impress me. That's what I thought, like, but it didn't!' (003d:6-7)

Meanwhile, Beth tried to keep her lifestyle as 'normal' as possible, so that her children would not feel different from other children:

'I don't want my problems to become their problems, you know. Because that easily happens to people. They use drugs and then like it becomes the kids' problems, and if you begin to live a life so different to everybody else, which isn't fair because they're not the ones - it's not their choice, is it. -- I like to try and keep the kids out of all that, not let my drug-using affect them. -- I just want them to feel like other kids do.'(011:3)

These two quotations epitomise two different strategies of protection for children, which left the respondents on the horns of a dilemma. If they presented their drug-use as 'normal' and not a 'novelty', children might be less inclined to experiment and thereby get into difficulties themselves in future. However, the strategy of 'normalising' a drug-using lifestyle was also seen to have inherent dangers, as it led to 'a life so different to everybody else', where children could no longer distinguish between normal and deviant lifestyles. As Heather explained: 'I feel that if I don't sort of sort something out now he's going to feel like it's normal to do them sort of things, isn't he. He's just going to feel it's quite normal to take drugs.' (021c:10)

She clearly feels that she has failed as a parent because she has been unable to provide her son with a 'normal' upbringing due to her drug-use. Her drug-use stops her feeling 'normal', and harms her son by distorting his understanding of what is 'normal' and not giving him a 'normal' childhood, so that he is justified, in her view, by responding with delinquency:

‘There’s nothing more that I’d like in this world, is just to wake up and be normal again. -- I stop myself from smacking him or punching him because I think, “Heather, it’s your fault why he’s like that. If you hadn’t had the lifestyle you’ve had he wouldn’t be - he may be not like that. If you’d have been a normal parent he might not be like that.”’ (021c:6,11)

Cathy, as an alcohol-user, shared these concerns, and confessed that, when her children were ‘taken into care it’s the first time that she [daughter] thought that things was, you know, not normal. She thought that it was normal, like’ (037:20).

Beth, who is currently using the strategy of deliberately not allowing drug-use to be seen as ‘normal’ in her home, explained what had happened to her eldest son:

‘he’d be left with my mum, and then like when I come back he’d see me, you know, all out me face type of thing. And that was how he looked at me, and that was the norm. The norm. Although he was so different from everybody else, it was normal for him to be that way.’ (011:3)

She later spoke about her distress when she realised that, as an adult, he was addicted to opiates:

‘when Alex started using drugs to that degree I knew he was because it was all there, all the signs and everything. But I didn’t want to believe that he was, you know. It took a lot for me to actually accept that he was doing it. And I know I kept thinking to myself, “Well surely to God he’d have learnt by my mistakes. He’s

seen what I've gone through. So how can he? He wouldn't do it, not to that degree'', you know what I mean. And it wasn't until he got registered that I accepted that he actually was in a mess with the drugs.' (011:18)

From the above quotations, it can be seen that, in relation to their current substance-use and their fears for their children in the future, there are two key problematics. One is the issue of being a contra role-model for their children, while at the same time attempting to inculcate a moral code for their children to follow. The second problematic is the issue of the 'normal', where the women simultaneously attempted to maintain a 'normal' family lifestyle for their children - so they would not feel different from others - while at the same time, within that lifestyle, attempting to demarcate their own substance-use as 'not normal' and thus not to be emulated (although also not defined as a potentially desirable 'novelty').

Summary

Many of the issues explored in this chapter clearly link back to the struggles of the respondents identified in the previous chapter to deal with a range of barriers to a 'normal family life'. Throughout these two chapters one can see the respondents working hard to negotiate and maintain control of their own autonomy and that of their families, in the face of structural challenges to that autonomy and despite social pressures which threaten to oust them from the category of 'normative mother' into the category of 'evil mother'. Thus the respondents present themselves as what I have termed 'reluctant non-conformists', far removed from the glamorous anti-heroes of the masculine drug or alcohol scene (Finestone, 1957; Sutter, 1966; Otto, 1981).

These are women for whom, as noted, the status of mother is central and who, rather than embracing their deviant status as 'junkies' or 'alcoholics', work to reduce its impact in their lives and any potential impact it may have on their children now or in the future. While holding traditional gender values around motherhood, they also demonstrate complex and painful responses to their children's gender, in particular showing a reliance on their sons as quasi-partners and an ambivalent relationship with their daughters based in some cases on their sense of powerless responsibility to protect them from sexual abuse. This problematic sense of ambiguous responsibility shows itself also in conflicting strategies designed to protect their children from possible future dependency on drugs or alcohol.

The following chapter explores the respondents' concepts of mothering more closely, identifying specific dimensions of 'good mothering' and linking these with more general notions of mothering held by the wider society.

Chapter Eight: Dimensions of 'Good Mothering'

Introduction

This chapter follows on from the previous chapter, where the focus of investigation was on the empirical doing and being of combining the two activities of mother and substance-user. This chapter takes the discussion further, by examining in more depth the theoretical implications of the respondents' actions and accounts, in order to begin to build an understanding of their concepts of what constitutes 'good mothering'. The respondents' accounts are linked into understandings of motherhood developed from studies of mothers in the wider community, to draw out continuities and contrasts between mothers in general and substance-using mothers. This chapter therefore addresses the questions, to what extent do substance-using mothers hold to an image of the traditional 'good wife and mother' prevalent in wider society, and how does this traditional notion of motherhood tie into their own views of themselves as mothers?

Traditional notions of being a good wife and mother

As we have already seen, Stella expressed very traditional notions of being a wife and mother, in that she stated (004b:3), for example, 'ideally I want to wake up and do housework and cook the tea ready for my man and kids and all that', and this view seemed to be widely shared, both by those currently with and currently without a partner. No respondent in this sample expressed any view significantly at variance with the prevailing accepted notions of being a 'good' wife and mother, with the possible exception of Carrie, who spoke about her relationship much more as a 'partnership' than did the other respondents, so that she said of her partner:

'We're as one -- he changes the nappies, he baths the kids, you know, he does what *I* do -- he'll cook a meal every night.' (025a:4) . Nevertheless, Carrie still very much subscribed to traditional concepts of being a good mother and took pride in the fact that her home was not like a 'junkie's home', an attitude echoed by many of the sample whether or not they felt that they personally were still able to attain appropriate standards. Annie, for example, although still subscribing to the traditional notion of the importance of a clean and tidy house, castigated herself for what she saw as her falling standards and thus her perceived loss of self-respect: 'I'm not as houseproud as I used to be. It's because I'm lazy now to what I used to be. At one time I wouldn't have stood *any* mess around me. -- Housework isn't such a big issue any more, it's like going to get the amps [ie. injectable ampoules of methadone] is the big issue.' (003b:12, 003e:8)

Adele, who was caring for a baby a few months old, shared with Annie the view that she *should* be doing more housework and guilt that she was not:

'I don't feel very energetic and I can't do all the things that I wanna do in the house, and when [partner's] around I don't feel right, I feel like I should be getting up and doing things, and getting the ironing done and - although he's really good and he'll do the ironing and stuff like that - no, no, I mean I believe in equal rights and stuff like that but at the end of the day I still believe men are men and women are women -- I get paranoid when I see [partner] doing it all. I feel like I should be helping him -- I really get into my head when I can't do things around the house.' (00A:9).

When asked about their future hopes, respondents again expressed views that tied into a traditional image of being a 'good wife and mother'. For example, Heather was quite clear about how she wanted to be in the future:

'Hopefully not taking heroin [laugh]. I don't know. Hopefully having a nice house, somewhere quiet, with my husband and a couple more children. And have a good job. Hopefully. Completely clean of drugs.' (021b:9)

Again, Patty and Sean, currently using heroin and supporting their habits through shoplifting and burglary, seemed adamant that they would prefer a more traditional lifestyle:

'We're hopefully going to start up a business, which is what we've planned. [Sean: -- we're going to set ourselves up. Say ten years providing the business goes well, we're hoping to own our own house. I don't want to stay on the dole all my life. No chance.]' (024a:30)

Thus the evidence from this and the two foregoing chapters is that the respondents seemed unlikely to revel in any way in their 'deviant' lifestyle. On the contrary, there was instead a sense that conformity to social norms, such as being a competent housewife and carer, were significant to respondents' self-images. Their use of substances such as heroin seemed far less related to visions from the 1960s of 'cats' (Finestone, 1957) or 'righteous dope fiends' (Sutter, 1966) than it was reminiscent at times almost of the nineteenth-century use of opiates such as laudanum, opium and morphine, as a necessary, everyday but somewhat

stigmatising medication, expressive of weakness and self-indulgence (Berridge and Edwards, 1981), and perhaps more recent use of psychoactive medication such as Valium (Cooperstock and Lennard, 1979; Helman 1981) or Prozac (Kramer, 1993; Wurtzel, 1995).

So far were the respondents from any glamorous associations with deviance and criminality in their substance-use that at times they appeared to genuinely forget their actions were illegal. Stella and her partner were clearly astonished when the police arrested them for possession of heroin on one occasion. Recalling the incident, they both admitted that they had quite forgotten heroin was illegal. While other respondents perhaps did not go so far as to forget that they were committing a serious offence in their use of heroin, nevertheless they too appeared to view its illegality merely as a necessary evil, a normalised and everyday part of life along with cigarettes, alcohol and tranquillisers. No wonder, under such circumstances, that they found it difficult to draw clear conceptual boundaries for their children between the 'normal', the 'deviant' or the attractively 'novel', as discussed in the previous chapter.

From this discussion, it would seem that respondents do hold to traditional notions of the centrality of being a 'good wife and mother', a finding replicated in previous studies (Rosenbaum, 1979, 1981a, 1981b; Colten, 1982; Stewart, 1987; Chadwick, 1988; Taylor, 1993; Kearney et al, 1994). This view of motherhood is not seriously disturbed by the fact, *per se*, that the women may be using an illegal substance: what does disturb their view of mothering is the threat posed by their perceived lack of competence in the role (through their own 'laziness', for example) or their perceived lack of ability to sufficiently 'take control' of their family life (through

factors outside their own control such as partner violence, homelessness, prison-sentences and so on). As has been shown in the two previous chapters, it is when this occurs that substance-using mothers feel most challenged in their ability to continue performing as traditional wives and mothers.

But what exactly does this notion of being a traditional 'good wife and mother' mean? As discussed in Chapter Four, to mother is regarded as to 'cherish, care and nurture' (Masson, 1995:210), and contemporary notions of how such cherishing, caring and nurturing may be worked out in practice are derived from two centuries of theorising about motherhood, from Rousseau in the 1760s, the Evangelical revival in Britain in the 1790s, the rise of psychoanalysis at the turn of the nineteenth century, up to Bowlby, Winnicott and the development of child psychology from the 1950s onwards. Thus, as discussed in Chapter Four, motherhood is a fluid social construct, varying with political, economic and cultural-ideological changes, and notions of motherhood are constantly being constructed, disseminated, received, negotiated, adapted, revised and contested in an endless process of development.

One key correlate of contemporary motherhood was identified in Chapter Four as mother-love: the socially-constructed responsibility to feel and express love for one's child. There is a strong social expectation that this felt love will be expressed in certain ways, such as through the practical daily work of caring for, disciplining, and 'bringing up' the child, identified by Ruddick (1990:61) as the three maternal practices of 'protection, nurturance, and training'.

Moreover, this work is expected to be conducted almost invisibly, without fanfare or acknowledgement, and without lapses and failures, merely with 'unobtrusive competence' (Graham, 1982:103). As Graham expresses it:

'Mothers are copers: they are individuals who can handle the pressures of their life calmly and effectively. The concept of coping pervades the way we talk about mothers. The greatest compliment you can pay a mother is to shake your head in wonder and murmur "I don't know how she copes": the most damning indictment you can pass is to suggest that "she can't really cope".' (Graham, 1982: 103)

But for many women such constant daily coping is hard to attain or maintain, leading to guilt and depression (Brown and Harris, 1978; Boulton, 1983; O'Connor, 1993). These negative feelings of low self-worth are all the more powerful because of the heavy moral weighting attached to the work of mothering, as discussed in Chapter Four. To be a true mother is to be a good mother. As Ruddick (1990:31) has described it: 'An idealised figure of the Good Mother casts a long shadow on many actual mothers' lives' and, as noted previously, any perceived failing at motherhood may become one aspect of women's 'hidden accounts' which is a key to understanding their lives yet which they find extremely difficult to disclose. Giving a 'public account' (Cornwell, 1985) of one's life, one may present oneself as a competent and able mother, a secure inhabitant of a status linked to adulthood and normative femininity (Winnicott, 1975; Chodorow, 1978; Breen, 1975; Dally, 1978, 1982). Even in more 'private accounts', one may reveal little of the deep disquiet associated with one's sense of failure at mothering. Only

in despair may one begin to approach disclosure the depth of misery which perceived failure at this 'master status' can provoke. The following account by Annie explores some of this pain, as she struggles with the notion that she herself is a deeply 'irresponsible mother', while continuing to hold to the traditional ideology of the central importance of the 'good mother' as her 'master status'.

A case-study: Annie (age 35, grandmother, with partner, three children ages 15, 10, and 6 years)

Among all the respondents, Annie expressed most openly and eloquently the conflict between her adherence to traditional notions of motherhood and the reality of her life as an opiate-user and 'bad mother'. At one point using the analogy of swearing at her children, she explored how her actions could be both 'normal' and 'wrong', simultaneously harmless (because no harm was intended) and harmful.

Annie shares the social understanding that mothers should not take illegal drugs in front of their children - that this behaviour is incompatible with the accepted norms of the role of mother (Kearney et al, 1994) - but at the same time she finds it hard to place herself in that category of 'drug-taking mother', because her drug-taking (smoking and dealing cannabis, injecting her methadone ampoules and swallowing her Dexedrine tablets every day, occasionally taking amphetamine, heroin and benzodiazepines recreationally) is a very normal and unexceptional part of her everyday life.

For her, within her personal and family life, her drug-taking activities are no longer deviant, they are compatible with her role as good mother until some external event acts as a prompt to remind her of the external social reality that drug-taking is sanctioned and stigmatised and that what she is doing falls into this sanctioned and

stigmatised category. Only at this point is she confronted with having to re-categorise herself again as a 'drug-taking mother' and therefore as 'bad', a self-description she has difficulty either *applying* to herself or *denying* as relevant to her actions. As she says, 'I've gotta see meself, because I wouldn't believe that I was ever that bad, unless I did see meself. It's only because it's obvious that I've *gotta* be that bad'. It is 'obvious' only when she is confronted by the external label 'drug-taking mother' and realises that it must apply to her, therefore she is forced to the conclusion that 'I've *gotta* be that bad', and even then there is tension and ambivalence: 'if things are wrong you normally stop doing them, don't you, really?'. As a 'good mother' Annie would stop doing something that was 'bad' and 'wrong'. She does not stop drug-taking. Annie therefore struggles with the implicit paradox that either she is 'good' and therefore what she is doing cannot really be 'wrong', or else it is 'wrong' and she is therefore 'bad' for continuing.

Annie criticised her own behaviour strongly, feeling that she salved her conscience with meaningless gestures of protection towards her children, and worried whether her behaviour would encourage them to use drugs themselves in the future:

'if anybody was to tell me what had gone on in my house - if somebody were to tell me what I *know* goes on, I think I'd be shocked by it. Like I'll sit on the pouffe and do me medicine, inject me medicine, and the kids will come in and I'll say to them, "Just go out a bit while I'm having me medicine", and - but they'll know what I'm doing, although I sort of cover meself by saying, "Go out", I mean they *can* still walk in and they know, they do sometimes and say, "I just want this." They don't take any notice,

but I mean it's fucking terrible really - but like I say I cover meself because I - I cover me conscience cos I do say to them, "Just go out a bit while I'm having me medicine", and it's *bollocks*! They shouldn't even be bloody - they shouldn't even *know* that that's how I have to do it, or they shouldn't be aware that it's okay to - you know, that it's alright to inject because people *don't* inject themselves, do they. You go to hospital to have an injection. I don't want them to think that it's alright to. -- it's sort of me saying it's alright for me to do it, but *you* can't. I mean I can't teach them not to do things if I'm fucking sat there doing it. But I really don't - I mean at the time I don't believe that I'm putting them - I don't believe that I'm encouraging them to do it, which is *crap* because I *must* be, you know, it's only obvious.' (003d:6)

Annie's struggle to negotiate and define her role - as 'good mother' or as 'irresponsible mother' - epitomises the struggle faced by many substance-using mothers in the study. Employing the psychoanalytically-derived conceptual framework of ego and alter to explore the sociological dynamics of her predicament (as used, for example, by Parsons, 1951), for Annie, ego is able successfully to split off the definition of 'dirty, desperate' drug-users from her own self-definition most of the time. As Annie says, 'I always think of, like, drug-users - dirty, desperate people, but then when I think of myself I don't think like that' (003e:7). However, this hermetic strategy of splitting herself off from a stigmatising category fractures when alter breaks in and discredits ego's self-definition, either in the form of an actual social actor or when Annie herself takes

on the role of alter in her imagination:

'if somebody ever took a video of me "gauching" [ie. affected by opiates], I think I would die -- if I could see myself, or see my kids - if somebody put a video in my room, you know, from morning till night and around me when I was wrecked - or when I *chose* to be wrecked - and how my kids were, and how I was, I'm sure I would stop, I really am sure -- if somebody were to tell me what I *know* goes on, I think I'd be shocked by it.' (003d:5-6)

Annie imagines the use of the video as a form of shock therapy, burning away the 'deviant' self-deceptions of ego in order to fuse ego once again into the normative value system of alter. By allowing her to perceive herself through alter's eyes, as she had been able to perceive the mother on a recent television programme, the Cook Report, she imagines the video technique as able to shock her into abstinence, in a personal ceremonial drama of degradation and discrediting (Garfinkel, 1956), which would have the power ultimately to cleanse and restore ego to the socially-appropriate role of 'good', no longer 'bad', mother.

'I was watching the Cook Report the other day -- a woman was selling draw [ie. cannabis] -- she was just stood there cutting the block [ie. 1lb weight] and the little kids was walking about, and it looked terrible! And I looked at it, and I thought, "What a fucking irresponsible mother!" -- you know how *them* kids are going to end up! And I thought, "Well, that's exactly what I do too, in front of my kids", you know, I'd think nothing of bringing in my cutting board here and cutting up me quarter into bits for the week -

although it ain't a *block* or whatever, it's nothing that I wouldn't think of doing. -- It's like when Jeremy shouts at the kids, I say to him "Don't fucking talk to them like that, it sounds horrible." and he says, "Well, look at you, you're fucking - you're always swearing at them." And I say, "But they know me, they know I don't mean it." But I mean it's still the same, but because I do it all the time it's like, well, no, they wouldn't think like that of me because they know that I - but I mean they *don't* know, do they, they just - you know, and it's really hard to really know just how wrong it is when you're actually the person who's doing the wrong. You gotta - I've gotta see meself, because I wouldn't believe that I was ever that bad, unless I did see meself. It's only because it's obvious that I've *gotta* be that bad. -- if things are wrong you normally stop doing them, don't you, really?' (003d:7)

Two of the key issues for Annie may therefore be seen as her failure to provide an appropriate role-model for her children and her lack of protection for them from 'wrong' behaviour such as drug-taking and swearing. Both of these dimensions of mothering link back to the traditional, Evangelical, notion of the mother as the guardian of moral values in the home (Hall, 1979), as well as to contemporary 'maternal practices' identified by Ruddick (1990), for example, as protection, nurturance and training. The next section looks in more depth at these and other dimensions of mothering identified by the respondents, and examines these dimensions in the light of more general studies on motherhood.

Discussion: dimensions of good mothering: responsibility and power

It would seem to be the case that we still know very little about what 'good mothering' is from mothers' own points of view (Rossi, 1973; Ribbens, 1994; Taylor, 1994). For Graham (1982), researching working-class mothers, taking primary responsibility for one's children was found to be a key theme. As Hughes et al (1980:26) have written, most mothers carry the burden 'of feeling continually and ultimately responsible for the health, development and happiness of their children ... [the mother] is the person beyond whom there is no recourse or appeal and who is answerable for whatever happens.' Rosenbaum's (1981a) study of heroin-using women also emphasised the perception of normative motherhood as crucially tied to responsibility, but does not break this sense of responsibility down into specific dimensions or tasks. One dimension identified from a study of 'ordinary' mothers (Dally, 1982), however, found that one of the responsibilities of 'good mothering' meant always being available for one's children, and this finding was confirmed in Taylor's (1994) study of opiate-injecting mothers. Taylor also found that her respondents 'made strenuous efforts to keep their drug life from affecting their children' (1994:111), for example by placing their children with relatives when their drug-use escalated.

This last finding is echoed in a study of crack-using mothers in the United States (Kearney et al, 1994). They found from a grounded theory analysis of a sample of 68 crack-using mothers that the mothers adhered to two main maternal goals, those of nurturing (including protecting) and role-modelling (including general socialisation skills). The sample evidenced four main strategies for achieving these goals in the face of dependent crack-use. The strategies were: separating children

and drug-use (so, for example, children did not see drug-consumption); separate budgeting of household and drug-buying finances; isolating themselves and their families from negatively-perceived social contacts (including social services); and, as a last resort when all else failed, giving up their children voluntarily in order that the goals of nurturing and role-modelling (including keeping their drug-use out of sight of children) could be met more effectively.

These studies begin to build a picture of motherhood, shared by drug-using (Rosenbaum, 1981a; Colten, 1982; Kearney et al, 1994; Taylor, 1994) and non drug-using mothers (Hughes et al, 1980; Dally, 1982; Graham, 1982; Ruddick, 1990) alike, of a contemporary form of socially-constructed mother-love (Badinter, 1981) which contains within itself the imperative of primary maternal responsibility, and that this responsibility can be tentatively broken down into the goals or practices of, firstly, being available; secondly, nurturing and protecting; and thirdly, training, socialising, and role-modelling.

In this study, issues around motherhood were most salient to those women whose children were around school-age and thus at the age where they are beginning to explore questions of responsibility and independence with their parents, but have not yet reached the stage of moving into independent living. This is the age when the nurturing aspects of motherhood may be beginning to decrease (relative to early childhood) but the role-modelling aspects are increasing in importance (Kearney et al, 1994).

In those interviews in which the respondents discussed their views on mothering, six key dimensions of 'good mothering' were identified. These were: being available for one's children (often discussed in the negative sense of defining 'bad

mothering' as not being available); one's children feeling able to communicate and confide in one; knowing one's own child well enough to know their limits and to encourage appropriate levels of responsibility in them; nurturing and taking responsibility for one's children; protecting children from the knowledge and consequences of parental drug-taking and also, specifically, protecting girls from sexual abuse. The dimension of role-modelling *per se* was not salient in these discussions although, as shown in the previous chapter and in the case-study of Annie, it can clearly be seen, for this sample, to tie into the dimension of protection.

Quotations from the interview-data illustrate these dimensions. Thus, for Annie, a key dimension of 'being a good mother' is about confiding and communicating, although Annie herself feels she is not living up to this model. When asked, 'What kind of a mother should you be?' she replied sadly:

'Well, I wished that I could just sit and talk to her. -- I wished that she was able to talk to me. I wish I could be like that. Because there's nothing worse than having nobody to talk to. Not being able to confide in me. Because then if ever she has got a problem or anything I ain't going to know.' (003c:7)

For Stella, 'being a good mother' contains the three dimensions of confiding and communicating; nurturing/taking responsibility; and protecting, as contrasted with 'being a bad mother':

'I think if you've got a good relationship you've got something good happening. If you haven't got a relationship, and you don't talk, I think there's something missing. Communication ... I think a bad mother is someone who leaves their child in the house on his own when she's out. I think a bad mother is who doesn't feed a child, who doesn't change a child ... that's what I call a bad mother. I don't think a bad mother's ... somebody who ... I just think neglect is a bad mother. And I don't feel I'm neglecting him ... -- A bad mother's somebody who leaves that child in danger, and there's no danger here. -- there's a place in my head for Derek, and it doesn't matter [how much heroin] I take or how I think, it doesn't go over that line where Derek is.' (004d:4)

For Beverley, 'being a good mother' contains the four dimensions of being available; being able to be confided in and trusted; taking responsibility and putting the children's needs first; and protecting children, specifically protecting her daughter from sexual abuse.

'A good mother is someone who's always there when they really need you, when times are hard they need someone to turn to, someone they can talk to, someone they can trust. Mainly that. -- I think a bad mother is a bad mother that goes out to pubs every night and has her kids sitting outside a pub all day long when she should be at home feeding them and when they come home from school there's no mum there. You know, they run round the streets, "Ah, where's me mum?" and all. Or a mother that thinks she should

buy a bottle before she buys a pair of shoes for the kids. -- [I used to think] if I ever have kids, any man that touches my kids I swear I'll fucking kill them. -- I always thought nobody would ever touch her. And for most of her life, when she got into fights and that, I always was out there fighting for her, getting myself into trouble. '

(001a:7, 001b:2)

Thus, from the interview-data, we have a model of 'being a good mother' which contains the six dimensions of availability, communication, encouraging responsibility, taking responsibility, protecting from knowledge of drug-use, and protecting from abuse. These can be analysed according to the models of 'maternal practices' of 'protection, nurturance, and training' (Ruddick, 1990:61) or the 'goals' of 'nurturing' and 'modelling' developed by Kearney et al (1994:354). From this study, the six dimensions are analysed into the two main tasks of *nurturing* (availability, communication, taking responsibility) and *maturational* (encouraging appropriate maturation while simultaneously protecting from inappropriate maturation). Thus Ruddick's practices of protection and training, and Kearney et al.'s goal of modelling (and the nurturant task of protection) are subsumed within the concept of assisting one's child to achieve the maturational tasks necessary for adulthood.

The following quotation from Stella demonstrates the concept of maturation as a key maternal task, in the sense of encouraging appropriate age-related levels of responsibility in her child:

'a lot of people say you shouldn't let your son do this or that, but I feel - I try and look at the whole picture -- Like Derek wanted to go to the shop by himself -- I said yeah, but I followed him without him knowing to see what he did, and he was great. -- I know them dangers, but I also know my son -- he's got to get the responsibilities and the younger the better. -- I know my son can cope with that. And I want him to cope with it. -- he's got to handle it, he's got to ... I've gotta spread him out a bit, and make him more independent, be himself, have his own personality.'

(004d:5)

Stella thus balances together the two aspects of the maturational task, of encouraging appropriate maturation while simultaneously providing protection to her son from the consequences of inappropriate maturational demands. The aspect of protecting one's child from a variety of potential threats, such as sexual assault and abuse (Nelson, 1987; Driver and Droisen, 1989; J. Kitzinger, 1991), global threats (Ruddick, 1990) or poverty and ill-health (Graham, 1984b, 1987a, 1992), is certainly seen as a fundamental aspect of motherhood in many contexts.

It could be argued that is in fact the perceived lack of protection which arouses the most social opprobrium and leads most readily to the categorising of a woman as an 'evil mother'. This is seen most clearly in cases where mothers are regarded as having 'colluded' with sexual abuse (Forward and Buck, 1978) or exposed children to the risks of drug-taking (Guardian, 1998a). In the paradigmatic case of the murdered five-year-old, Dillon Hull, referred to in Chapter One, it is Dillon's mother, rather than the murderer or indeed his step-father who was with him at the

time of the murder, who is seen to have failed in her responsibility to protect her child, by not re-locating her home away from a known drug-using area.

But protection, to be effective, is dependent on access to power. As we have seen in Chapter Five on the respondents' own experiences of being mothered, and in Chapter Six where respondents talked about attempting, and failing, to protect their daughters from sexual abuse, even in this arena the respondents had experienced first their own mothers, and later themselves, as responsible but powerless to effectively protect their children.

The issue of power, contrasted with powerless responsibility, runs as a key theme throughout this thesis. The power of motherhood is a vexed question: as Rowbotham (1989:88) has described, for many women motherhood conjures up an image of 'power and submission bound together', with the powerful image of the Earth Mother linked inextricably to what Mary Kelly (1980:68) has called the 'iconography of victimisation' inherent in images of 'women's work'. Fantasies of the all-powerful, all-protective mother continue to lie deep in the subconscious, decades after the actual experiences of infant helplessness and need, and continue to provoke in our adult selves love for the 'nurturing' mother and rage at the 'withholding' mother (Chodorow and Contratto, 1982).

Primary responsibility for children and the consequent power arising from motherhood can never be anything other than problematic for women, as many writers and theorists have explored (Firestone, 1971; Mitchell, 1971; de Beauvoir, 1972; Chodorow, 1978; Piercy, 1979; Delphy, 1992); nevertheless it remains true that maternal power does constitute a source of power and agency available to women under patriarchy (New and David, 1985; Gordon, 1986; Johnson, 1988;

Ribbens, 1993, 1994). This power, present in the private sphere while often simultaneously absent in the public sphere (Ribbens, 1994), thus becomes an experience both constraining and enabling for women (Allen and Crow, 1990), constituted of power and powerlessness (New and David, 1985), of freedom and unfreedom (Morgan, 1985). The 'family home', constituted as a private setting, remains conceptualised within contemporary western society as the heartland of maternal authority and power (Stolz, 1967; Stacey and Price, 1981; Ribbens, 1993).

Rich (1977:67) has spelt out the parameters of this maternal authority and power:

'the helplessness of the child confers a certain narrow kind of power on the mother everywhere - a power she may not desire, but also often a power which may compensate her for her powerlessness everywhere else. The power of the mother is, first of all, to give or withhold nourishment and warmth, to give or withhold survival itself.'

Less dramatically, New and David (1985:22) chart the mundanity of this use of everyday maternal power:

'A lot of childrearing consists of calming children down, controlling and managing them, getting them to submit and to accept the unacceptable. These processes are not at all neutral. Inevitably they are carried out by mothers who have enormous power over their children, even though they are otherwise not very powerful.'

Maternal power can thus be seen as channelled to serve the needs of wider social norms, for example the needs of patriarchy for girls trained for subservience, tying in with the previous discussion, in Chapter Five, on women as 'wildly unmothered' under patriarchy, since their mothers, although endowed with maternal power, are not actually able to effectively prevent harm or abuse befalling their children.

The protective dimension of maternal power and responsibility contains a double-edged social obligation, both to exert control over their children (as the New and David quotation (1985:22) makes clear) but also to mediate interactions between their children and wider society (Graham, 1984b), keeping harmful social influences at bay (Ribbens, 1994).

The protective power of mothers thus operates in two directions simultaneously, protecting society from children and children from society, bringing us back to the two visions of childhood as conceived by Jenks (1996), of the Dionysian child from whom society requires protection and the Apollonian child who itself requires protection from society. To these two images of childhood may be added a third, that of the child simply as a small person (Ribbens, 1994). The 'child as small person' is neither a 'little devil' nor a 'natural innocent' but an individual with 'rights as well as needs' (Ribbens, 1994:151).

This 'child as small person' brings into the discussion on protection a more complex pattern of interaction than the Dionysian and Apollonian dichotomy of protection *of* society or protection *from* society. It would seem to be this vision of childhood which is being evoked when the respondents in this study talked about their children in terms of encouraging appropriate maturation while protecting from inappropriate maturation.

This complex maternal task of assisting maturation is illustrated in the following quotation by Patricia, where her children are seen as having a right to protection (from being 'on the street') and a right to self-determination (or 'their own space') and *not* being protected 'all the time':

'I think it's important to give kids their own space -- The children that are out there, streetwise and whatever, cope with the problem. All of mine are streetwise. -- I know they'll do what they are supposed to do. They know it's got to be, I can't watch them all the time -- They all have their own responsibilities, I don't believe in being a slave to them. They have to wash up at night and do this and do that. I don't think it's good protecting them all the time. They don't learn anything that way. But I don't leave them out on the street all the time either. I don't like them on the street really.'

(006c:10-11)

The respondents' children are thus seen as having a 'right' to be protected from harm, such as the effects of maternal drug-abuse, and a 'right' to make their own way and experiment for themselves, a right which mothers such as Hilary, Patricia and Stella evoke when they say:

'if Mary-Beth wants to take Ecstasy or smoke draw I can't say anything because I've done it myself. But I will talk to her. I'll advise her -- I'd say "If you want to carry on, you carry on. -- Learn for yourself. I'm only telling you what's happened."' (Hilary, 022b:17-18)

'let's hope they've got more sense that to take drugs and smoke and drink and whatever, hopefully they will, you know, I can't do much more than that, can I. -- I think they should have learnt by my and [husband's] mistakes, really ' (Patricia, 006c:8-10)

'I wouldn't sit there and smoke it in front of her, but it was because she caught me and she needed to know. -- [Her younger son] he needs to understand.' (Stella, 004d:4)

This vision of childhood is less dependent on notions of discipline than the Dionysian model, and at the same time less protective of 'innocence' than the Apollonian model. It is a view which asserts the individuality of the child and which values and endorses children's behaviour which is resourceful, independent and 'adult'. Significantly, the issue of discipline was one which was not referred to by the respondents as a dimension of 'being a good mother' and no respondent referred either to the issue of children being 'innocent'.

Summary

What this study of substance-using mothers has revealed is the depth of adherence to traditional notions of 'good mothering', that mothers should take on the traditional tasks of good housekeeping, should be available for their children, should be able to communicate with them and be confided in, and should protect them from inappropriate maturation while at the same time encouraging them in appropriate maturational tasks and preparing them for independence and adulthood. There is much evidence that where substance-using mothers feel they are failing in these tasks, like many other mothers they experience a sense of low

self-worth, guilt and depression, although it is also likely that the true extent of such emotions may be hard to access in a research context, due to the salience of motherhood as a 'master status' in which it is discreditable and stigmatising to be seen to be failing, thus keeping much emotional pain in this area at the level of 'hidden accounts'. Nevertheless, it seems clear that far from any sense of rebellion against the norms of motherhood, the women in this study are 'reluctant non-conformists', working hard to maintain a 'normal family life' despite many barriers.

There is also some intriguing evidence from this study that the gender of the children may play a key role in the mother-child relationship. Following on from the discussion of the respondents' difficult upbringings in Chapter Five, there is evidence that, as in other studies of mother-daughter relationships (Rich, 1977; Flax, 1978; Kaplan, 1992), the women continue to have troubled relationships with their mothers into adulthood and their own experiences of mothering may be negatively affected by this. Ribbens (1994) has suggested that women who subjectively identify more strongly with their fathers than their mothers may experience a greater sense of questioning and self-doubt in relation to their own childrearing, and it certainly seems to be the case that respondents generally felt they had to find their own way in their parenting, often diametrically opposed to the parenting they themselves received. Part of their difficulty lay in establishing comfortable and protective relationships with their own daughters, and for some respondents this included the issue of protecting, or failing to protect, their children from sexual abuse.

Perhaps related to their problematic relationships with their daughters, respondents tended to view their sons in a very positive light, as companions and helpers,

almost taking on the role of adult partners. Unlike other studies on motherhood, such as the study by Ribbens (1994), where mothers spent a great deal of time and effort mediating between their children and their partners and discuss their mothering in terms of 'shared parenting', mothers in this study were more likely to take on almost all parenting tasks and see themselves as almost totally and exclusively responsible for their children, whether or not they had partners living with them. For some mothers at least, this fact, coupled with their view of children, especially sons, as 'small people' (Ribbens, 1994), may encourage them to forge their strongest relationships with their children rather than with other adults. To re-visit the quotation from Beck (1992:118), from Chapter Four:

'The child is the source of the last remaining, irrevocable, unexchangeable primary relationship. Partners come and go. The child stays. Everything that is desired, but not realizable in the relationship, is directed to the child. With the increasing fragility of the relationship between the sexes the child acquires a monopoly on practical companionship, on an expression of feelings in a biological give and take that otherwise is becoming increasingly uncommon and doubtful....The child becomes the final alternative to loneliness'.

This heightened salience of the mother-child relationship may make any intervention by outside agencies, such as social services departments or other family-members, extremely painful to the mother, as it threatens perhaps the most meaningful and rewarding relationship she has. Thus, in a situation where the mother is far more vulnerable to barriers to 'normal family life' and where she is far more likely to have to struggle to 'take control', the stakes appear to be raised yet

higher than they might under other circumstances, since it is not only her 'master status' as mother but also perhaps her central and primary relationship with her child which may under threat of dissolution when she is seen as failing to cope in her mothering.

The following chapter draws together the themes relating to the respondents' substance-use which have been identified in the interview-data, and makes explicit the varied ways in which the respondents' substance-use can be understood as assisting them to cope with their lives as mothers and women under patriarchy.

Chapter Nine: Summarising Functions of Substance-use in Respondents' Lives

Introduction

As mentioned in Chapter Three on contemporary substance-use, this thesis draws on a wide range of studies on substance-use, including the work of Hilary Graham on the use of cigarettes among mothers as a strategy to help them with 'coping and caring' (1982, 1984b, 1987b, 1993a), work by Cooperstock and Parnell (1982), Helman (1981), Prather (1990), Ettorre and Riska (1995) and others on women's use of tranquillisers, and the studies by Rosenbaum (1981a), Colten (1982), Taylor (1993) and others on women's use of illicit drugs, mainly opiates.

These studies provided a conceptual framework for understanding women's use of psychoactive substances. For example, Graham (1993a) identified a range of functions performed by cigarettes in the lives of a sample of White working-class mothers of young children. The functions which she found can be divided along two major dimensions, those of time-management and mood-management. A third dimension, mentioned in passing by Graham (1993a:34) is the use of cigarettes to establish and maintain adult social relationships (Gubbay, 1992).

These dimensions are listed overleaf in Figure 11.

Functions of Cigarette Smoking
Among Young Mothers
(derived from Graham, 1993a)

(1) Time Management

Breaks from caring

Time for oneself

Adult time with partner or friends (rather than child-centred time)

(2) Mood Management

Relieving stress, tension, worry, feelings of being upset, under pressure, on edge

Relieving depression

Relieving boredom or monotony

Dealing with anger and avoiding physical abuse of children

Providing order, calm and patience

Supplying a sense of energy

Providing symbolic space for pleasure, treat or reward

(3) Establish and Maintain Adult Social Relations

Graham (1993a) also identified from her study that smoking, and heavy smoking in particular, was more likely to occur among mothers with higher numbers of children; those who found the behaviour of their children hard to cope with; those who were providing 'special care', for example to a family-member with a disability; those who rented accommodation or moved home frequently; those on benefits; those with partners who also smoked; those who lived in a household where no-one was employed; and those who scored highly on an index of

deprivation, for example not having access to a car/van or a telephone and being in debt. All of these circumstances clearly increase the level of stress that mothers will experience, adding weight to the view that cigarette-smoking is a coping strategy for those women struggling to maintain their family responsibilities and continue coping and caring despite a lack of resources.

These identified functions of cigarette-use were used as a starting-point for investigating the role of psychoactive substances more broadly in mothers' lives in this study and, as will be seen, there are clear links between the ways in which working-class mothers use cigarettes in Graham's sample, and the ways in which mothers use psychoactive substances in this current sample. This will be discussed in more depth in the final section, after each function of substance-use identified from this study has been illustrated and discussed.

Functions of substance-use within everyday life

In analysing the interview transcripts from this study, over one hundred instances were coded where the functions of substances were mentioned. These instances were then thematically grouped according to the function identified, giving seven main functions altogether.

These functions are listed overleaf in Figure 12.

Functions of Psychoactive Substance-use Among Mothers in this Study

- **Pleasure**
- **Everyday Mood Management**
- **Dealing with Specific Difficulties of Daily Life**
- **Dealing with Past and Ongoing Trauma**
- **Adult Relationship Management**
- **Task Performance**
- **Using Substances to Manage Other Substance-use**

The seven functions will now be discussed in turn.

Pleasure

A significant aspect of any form of substance-use is, of course, pleasure (Newcombe, 1989; Mugford, 1991; Ettorre, 1989, 1997; Henderson, 1993a, 1993b) . Just as the respondents in Graham's study (1987b; 1993) talked about smoking cigarettes to give themselves a treat, so the respondents in this study spoke about a range of substances which they used for pleasure. Cannabis, injectable methadone, methadone linctus, heroin, gas, alcohol, and tablets such as Temazepam and other 'sleeping tablets' were all described in terms expressing pleasure, and two women (Annie and Margaret) even described themselves as 'greedy' in their desire to take Temazepam and other tablets, with Annie saying, 'I had two sleeping tablets -- I was feeling greedy. -- I had to have two, cos I'm a greedy mare. Greed, that's all it is, honestly, it's greed -- Any drugs, any.' (003e:8). Heroin particularly was talked about as something loved, used for

pleasure and recreation, and as a treat, Carrie for example saying of her use of heroin: 'we'd have the odd bag just for pleasure.' (025b:29). Alison and Gloria spoke about buying heroin as a treat when they had a little money spare to spend on themselves. As Alison described it: 'I don't spend anything on myself. Very, very rare.-- The only time I do take smack as well is when I've had an earner'. (020:13)

Everyday mood management

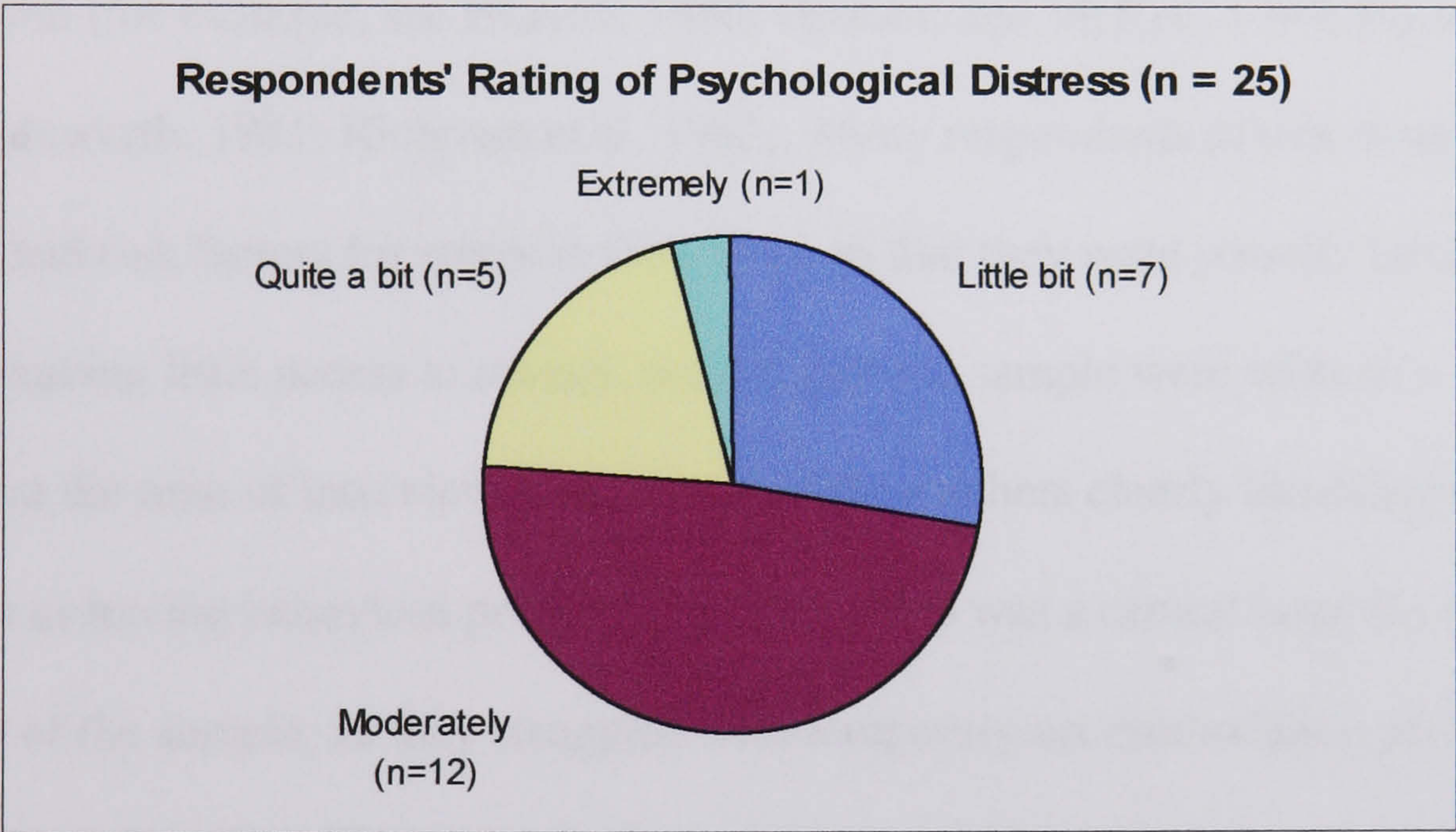
The second function identified from the data was that of everyday mood management, and this appeared to be perhaps the most significant function for the respondents, judging by the number of explicit references to it in the interview-material, accounting for just over a quarter of all identified references to the functions of substance-use.

This function is equivalent to Graham's finding that cigarettes are used by women to stay calm and not get 'ratty', and to the findings by, among others, Cooperstock and Lennard (1979), Helman (1981), and Prather (1990) on women's tranquilliser-use, which seem linked to allowing users to perform their social and familial roles competently. In this sample, respondents spoke about using opiates, sleeping-tablets and 'pills', amphetamine and Dexedrine, cannabis, and alcohol to control a range of negative emotions (such as lethargy and 'laziness', depression, boredom, stress, loneliness, and guilt) and provide positive emotions (such as sociability, courage and confidence).

As mentioned in Chapter Two, the respondents' level of psychological distress was measured using a self-administered rating scale (the Derogatis SCL-90-R), a

standard scale used in psychological, psychiatric and counselling treatment and research and measuring levels of somatisation, obsessive-compulsive disorder, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism (SCL-90-R, 1999). Twenty-five respondents completed this instrument, and no significant correlations emerged between the type of substance used and the level or type of psychological distress.

Figure 13 shows the number of respondents reporting how much they were generally worried by symptoms of psychological distress.



Psychological distress was measured by respondents reporting how much, over the previous month, they had been 'bothered' by such symptoms as sleeplessness, anger, loneliness and so on, rated as 'not at all', 'a little bit', 'moderately', 'quite a bit', or 'extremely'. Their responses to the 90 symptom-variables were then aggregated to give a general indication of each respondent's level of distress. No respondent indicated that they were 'not at all' bothered by any of the symptoms listed.

Respondents were least likely to report psychotic, paranoid, obsessive-compulsive, or hostile symptomatology, and most likely to report anxious and depressed symptomatology such as extreme levels of worrying, difficulty remembering things, feeling guilty and blaming themselves, having low energy, and feeling nervous and easily hurt by others. In sum, as shown in Figure 13, the 25 respondents who completed this instrument were very likely to experience moderate degrees of distress, which were typically manifested in symptoms of depression and anxiety.

This is not a surprising finding, given that previous studies on populations of other mothers have tended to find indications of clinically-significant stress and depression (for example, see Evason, 1980; Graham and McKee, 1980; Burnell and Wadsworth, 1981; Richman et al, 1982). Many respondents in this current sample had risk factors for stress in their lives, in that they were socially isolated as well as having little access to money, around half the sample were without a partner at the time of interview, and several of the mothers clearly identified their children as having behaviour problems. Housing also was a central issue for a small number of the sample, as they struggled with temporary accommodation and waited for re-housing. Thus it is clear that they were at high risk of anxiety and depression, and showed many behaviours and attitudes consonant with this. Their use of psychoactive substances can be viewed as one way in which they coped with this sense of malaise. As Graham (1984b:81) observes, 'tranquillisers do not so much cure depression as enable their users to cope with the responsibilities which trigger it.'

It is of note in this respect that 'street drugs', cannabis and amphetamine appear to be explicitly preferred as alternatives to 'anti-depressants', so that for example

Beverley, who had previously attempted suicide by taking an overdose of anti-depressants, asserted: 'I'd rather have cannabis as an anti-depressant than anti-depressants. It's a less harmful substance. Cannabis, you can't overdose yourself on it.' (001d:1). Penny found that, although she was on prescribed Prozac, 'then again, once you've had speed [ie. amphetamine] and you're feeling well, that's even better. So I take that, you see. That's how I was well again.' (023:16).

The use of illicit substances as lay 'anti-depressants' is linked to the use of illicitly-obtained anti-depressants and tranquillisers for recreational purposes or self-medication, thus contributing to the blurring of distinctions between 'medicine' and 'street drugs', and between substances to treat an illness and substances for enjoyment. For example, in one study (Prather, 1990), respondents regarded their tranquillisers as an everyday part of their lives, and kept their medication in their purses and kitchen cupboards rather than in the bathroom cabinet, thus demonstrating how, for them, tranquillisers had moved from a specialised 'medicine' to a routine part of life, much as Helman's (1981) respondents viewed tranquillisers as everyday 'fuel' or 'food', saying, for example, 'But it's just like taking a biscuit with tea.' (Helman, 1981:533).

Respondents talked about being given prescribed tablets by relatives or friends, or buying them on the black market, and this is consonant with other studies (Cooperstock and Parnell, 1982; Prather, 1990; Ettorre and Riska, 1995).

Research has shown that those using tranquillisers or barbiturates often admit to sharing or receiving their medication with lay others: figures range from 10% of users in a sample (Fejer and Smart, 1973) to 12% (Helman, 1981), 26% (Ettorre and Riska, 1995) or even as high as 68% among young adults (Warburton, 1978).

Another interesting finding was that substances appeared at times to be used paradoxically, thus Adele used heroin, a central nervous system depressant, to combat lethargy; Clare used 'sleeping tablets' as a pick-me-up; and amphetamine, a stimulant, was used by Angela and Carrie to calm them down. Overall, in terms of everyday mood management, it would appear from the references to function in this interview-sample that opiates, especially heroin, were used to combat lethargy and boredom, to 'think nothing' and feel nice and warm. Amphetamines, including Dexedrine, were used to give courage and sociability, to combat laziness, to feel normal, calm and cheerful, for confidence, to combat depression, and to cope with 'nerves'. Tablets such as sleeping-pills were used as a pick-me-up, to 'blank out', to 'feel like a zombie', and to calm down. Alcohol was used for confidence, to combat loneliness, to reduce stress, to cope with guilt feelings, to give courage when going out and to blot out feelings. Cannabis was used mainly to combat depression, to feel calm and cheerful and 'normal'.

Dealing with difficulties of daily life

The previous function of substances to regulate one's mood is linked to this function, where respondents talked about substances as useful in assisting with specific difficulties in daily life, such as panic attacks (Valium), postnatal depression (heroin, alcohol), having to tolerate unwanted sex with a partner (heroin), dealing with the loss of a supportive relationship (heroin), staying calm while in prison (heroin), stress of committing fraud as daily work (alcohol), rowing with a partner (heroin) or dealing with a difficult child (heroin), for physical pain (amphetamine, cannabis, opiates), to stay calm when in a meeting with professionals (cannabis, amphetamine, heroin), to provide something to do to 'fill

up' the day (heroin), to lose weight (amphetamine), to behave at school when younger (amphetamine), to cope with an 'empty nest' when adult children left home (alcohol), and generally to cope with unspecified problems and crises (heroin, alcohol).

Past and ongoing trauma

Unlike the previous difficulties of daily living which, although painful, are generally acute and limited in duration, respondents also spoke about using substances to deal with chronic trauma, where the reverberations of the traumatic episode, such as bereavement, may last for many years, or where indeed the trauma, such as domestic violence, may itself continue unabated for years. Eleven respondents could point to a specific traumatic episode which they identified as a key factor in beginning dependent substance-use, the episode being bereavement (n = 4), childhood sexual abuse (n = 4), divorce (n = 1), burglary (n = 1), or life-threatening illness of a baby (n = 1); others spoke about their substance-use as helping them through ongoing trauma now, including domestic violence (alcohol and prescribed benzodiazepines) and recent bereavement of a child (amphetamine).

Adult relationship management

Preserving the relationship with an adult partner is a function that has been identified for tranquilliser-use (Cooperstock and Lennard, 1979; Helman, 1981; Prather, 1990; Ettorre and Riska, 1995). For example Helman (1981) identified one reason for taking medication long-term as maintaining or improving relationships within the family, stating (1981:527), 'for some patients the drug was taken as much for the benefit of others, as for their own benefit.'

This function also seems implicit in Graham's (1987b) understanding of cigarette-use as playing a part in women's role as 'copers and carers'. This understanding of women as 'copers and carers' suggests that men are not only *not* responsible for the coping and caring necessary in family life, but are in fact typically those who are *coped with* as well as *cared about*. It is by now a commonplace that the responsibility of 'emotional housework' falls most heavily on women (for example, see Graham, 1983, 1984b, 1985b; Bell, 1990; Bertaux and Delacroix, 1992; Duncombe and Marsden, 1993; Ribbens, 1994). Thus the strain of 'emotional housework' in adult relationships and family life typically falls on female shoulders, whether this is in the context of a generally supportive relationship or otherwise.

To some extent this function is subsumed with the previous functions, as is shown for example by one respondent (Deborah) using heroin in order to tolerate sex with her partner, or other respondents using substances to deal with domestic violence or depression. In addition, four respondents referred explicitly to the function of substance-use in maintaining their relationships, with Annie and Hilary choosing to begin heroin-use and amphetamine-use respectively in order to preserve a relationship; Stella sharing heroin experimentation with her new partner; and Patty and her partner finding that heroin-use improved their relationship and stopped her partner's physical violence against her. The experience of other respondents, while less explicitly identified, also pointed towards relationship-maintenance as an important function of much substance-use.

Task performance

A common-sense understanding of substance-use would suggest that it would have a largely negative impact on task performance, and it is a counter-intuitive finding

that in fact respondents found a wide range of substances helpful in performing housework and childcare tasks. For example, Adele explicitly justified her heroin-use in terms of enabling her to complete household tasks, despite the fact that generally heroin is considered a sedative drug:

‘I don’t feel very energetic and I can’t do all the things that I wanna do in the house -- I feel like I should be getting up and doing things, and getting the ironing done -- I think “Oh, I’ll just go and get a bag, I’ll have a bit of energy and clean the house from top to bottom”’. (00A:9)

Similarly, Beverley commented that, when smoking crack, while her partner would ‘sit down and be relaxed’, she ‘was just getting up running round doing all my housework, cleaning, making cups of coffee, things like that.’ (001b:4-5). Mandy found that cannabis made housework more enjoyable: ‘say like I’ve got it now and I started doing my housework, you’re going to get into it, being stoned’ (041:2). Annie, meanwhile, positively recommended prescribed amphetamine tablets for ‘lazy women’ or those with a ‘problem’ getting their housework done:

‘I used to have to do everything by a set time and it really used to frustrate me if things weren’t done and for people like that I think they should give them Dexedrine, cos it used to be a right nightmare for me, before; like now I just do it all in me stride, not so much a problem anymore.’ (003e:7).

Not only housework but also childcare was seen as assisted by substance-use, ranging from smoking cannabis in order to cope with leaving the house to take the

children to school in the morning, for one respondent suffering from 'nerves', to drinking alcohol all night when having to stay up with a hyperactive child who was unable to sleep. Chris found that after smoking crack she was less likely to shout at her child and more likely to enjoy playing with him, and Patty described how heroin helped her overcome postnatal depression and care for her baby:

'Everything was just a task and when I started taking heroin it was brilliant. I could do everything, I could get everything done, get the bottles done and everything.' (024a:8).

Amphetamine was used by Joyce to care for her chronically ill children over many years:

'I had a go at everything, but I stuck with the amphetamines, because they kept me awake and kept me going. Of course when I realised that the kids had got [a severe degenerative disease] it helped me because it was a twenty-four hour job. -- It was hard work. The amphetamines came in very handy. I wasn't sleeping, I wasn't eating. But I was awake for [terminally-ill child], I was there.' (017: 5, 10).

The finding that opiate-using mothers may use opiates to assist them in daily tasks has been commented on previously in other writings (Jeffries, 1983; Stewart, 1987). For example, back in 1979, Rosenbaum wrote (1979:431), that, for mothers, 'Heroin becomes a mechanism for coping with the routine difficulties of childraising.' Similarly, an opiate-injecting mother in Taylor's study (1993: 109) commented:

‘I’ve got all these bottles to make up and I’ve got to do all her washing and I’m feeling kind of tired and then I’ll think, “I feel like a hit” and once I’ve had that I can go and do it all, dae [do] the washing. It just gives me the energy.’

However, little has been made of this finding to date: perhaps the notion that ‘Women will go out and get heroin to help with the ironing’ (Coventry Evening Telegraph, 1996) is simply too far from either the category of ‘normative mother’ or ‘subcultural deviant’ to be taken seriously. Even in the substance-use literature, while opiate-use may fleetingly be acknowledged in this role, the fact that other substances also, such as crack, are drawn on for this purpose has so far received little recognition.

Using substances to manage other substance-use

The final function identified from the research-data is using one substance to control the use of another substance. Thus just as, historically, opium has been used to treat alcoholism, and cocaine has been used to treat opiate-addiction (Berridge and Edwards, 1981), and today methadone is used to treat heroin-addiction and Dexedrine is used to treat amphetamine-dependency, so the respondents used a range of substances to treat or manage their dependency on other substances.

Substances were used in three main ways, to wean themselves off the primary substance, to help them through withdrawals, or to see them through a ‘drought’ of that substance. In this sample, respondents referred to using cannabis and

alcohol to stop crack and heroin use (Beverley), speed to stop heroin and methadone use (Annie), Temazepam and cannabis to stay off 'hard drugs' generally (Margaret), cannabis to avoid alcohol (Marlene), and cannabis to replace heroin (Heather).

For heroin withdrawals, respondents used Valium (Stella), codeine (Marlene), and painkillers from a grandmother (Patty and her partner). Two respondents (Patty and Donna) volunteered that they did not find cannabis helpful in heroin withdrawals, although other respondents indicated that they did use cannabis in this way. Heroin was used by Carrie to deal with the after-effects of crack-cocaine, and cannabis was used by Mandy and Maureen for the after-effects of amphetamine, with Maureen also using 'sleeping pills' for this purpose. Cannabis was used by Hilary to cope with an amphetamine 'drought', and alcohol was used by Maxine to cope with a cannabis 'drought'.

Discussion: making sense of women's substance-use within the context of patriarchy

The foregoing discussion in this chapter has investigated a range of functions which the respondents identified substances as performing in their lives, functions which clearly provide powerful motivations for continuing substance-use regardless of any perceived disadvantages and regardless of whether the substances on which women are psychologically dependent are physically addictive or not.

These seven identified functions derived from grounded-theory analysis of the interview-data link back to the discussion first raised in Chapter Two regarding a feminist analysis of women's substance-use in contemporary society. Against a

background of more general oppression as women and as mothers, the discussion highlighted five specific dimensions of substance-using women's experiences linked to the increased acceptability of the pursuit of pleasure among women, role strains within the 'feminine' role, the burdens of domestic caring, the existence of underlying trauma such as childhood sexual abuse, and the acceptability of 'dependence' for women although not for men. The functions identified in this study also link closely, as noted, to the body of work by Graham (1993a) on the role of cigarettes in the lives of White working-class mothers of young children.

The function of substances as pleasurable and rewarding can be seen as part of a much wider cultural movement, in existence since the 1950s and associated with the rise of second-wave feminism (Friedan, 1963; Oakley, 1974), in which women have become increasingly able to move away from narrow definitions of their role as 'housewife and mother' towards a greater sense of autonomy, self-definition and self-actualisation. Using substances explicitly for pleasure has become more common and acceptable for women (Ettorre, 1989; Henderson, 1993a, 1993b).

Psychoactive substances are egalitarian in that they do not discriminate in providing pleasure to women or men, and can offer a compensation for women disillusioned with the role of mother, as well as a source of excitement and challenge (Rosenbaum, 1981a, 1981b; Taylor, 1993). 'Taking care of business' has long been recognised as a source of satisfaction and pride for male drug-users (Preble and Casey, 1968) and is increasingly recognised as satisfying also for women, since the expertise and skill needed in obtaining money, locating, buying and finally administering their drugs, especially by injection, may all contribute to a woman's sense of competence, satisfaction and esteem (Stewart, 1987; Taylor, 1993).

Stimulants such as amphetamines (DAWN, 1986; Gritz and Crane, 1991; Klee, 1998) and crack (Newcombe, 1989; Lusane, 1992; Kossoff, 1994; White, 1994) have been viewed as especially alluring to women in that they provide the sense of power and confidence which is otherwise lacking in many women's lives (Henderson, 1993a, 1993b; Ettorre, 1992, 1997). As Kossoff (1994:14) writes: 'One of crack's main attractions for women is that it deludes them into believing they can overcome society's sexism and the lack of self-esteem which it creates', and similarly a specialist women's worker focussing on crack-use sees crack as 'a secretive, "my own little world", drug' (Louise Clarke, quoted in Community Care, 1994). Thus these substances are seen as providing a sense of pleasure from a vision of oneself as 'superwoman' and insulated from cares of daily life, but this pleasure is understood as ultimately hollow, since it is founded on illusion.

Alcohol too may be regarded in this light, since its use can be viewed as freeing the woman to forget her troubles and enter her own private world for a period. Several respondents referred to alcohol as permitting escape into this private 'rosy' world, and Geraldine especially commented:

'when I used to drink I used to think it was going to be wonderful. My marriage is going to be great again. The kids are going to be good. And you go into this imaginary world that everything is going to be okay. -- I can remember now sitting on the settee thinking "Oh, he's wonderful. It's going to be great, and it'll be fine. He'll help me as much as I need him to help me" and things like that. And it just doesn't happen. But alcohol used to make me think that everything was alright.' (035:15).

Escaping into this fantasy world of powerful self-confidence or an ideal family life may be the only pleasure available for women for whom other options for autonomy and satisfaction are closed off.

The function of everyday mood management, which clearly may include pleasure but also for many respondents included management of negative mood-states such as depression, can be seen as linked theoretically to the management of role strain identified by Cooperstock (Cooperstock and Lennard, 1979) who investigated tranquilliser use as a means of maintaining a given social role. Tranquillisers were seen as enabling users to maintain themselves in roles which they found difficult or intolerable without the drug. Thus, in Cooperstock's view, tranquillisers work to sustain strained social systems (although this appears to be true only for female users: male users typically use it to facilitate occupational rather than relational roles). In this study, the respondents' use of substances to combat depression, loneliness, boredom, stress and guilt, and to boost a sense of sociability, courage and confidence can be seen as enabling better role performance as partners and particularly as mothers. This is especially true of their use of substances to give energy and combat lethargy and 'laziness', but may also be strongly linked to a sense of tedium and dissatisfaction with motherhood, and a related sense of guilt and self-blame for not finding the role of motherhood as fulfilling as anticipated (Boulton, 1983; Holdsworth, 1988; Taylor, 1993).

Many women in Cooperstock's study (Cooperstock and Lennard, 1979) reported initial tranquilliser use following the birth of their children and the physical and emotional strains of this time. Particularly where the children were seen as difficult, or had physical impairments or learning difficulties, this initial use tended to then

develop into long-term use. Tranquilliser use had also begun subsequent to widowhood or separation, and Cooperstock relates such use less to grief than to the strain of adapting to a new role.

In this regard it is interesting that, out of the forty-eight respondents, sixteen women referred to twenty-one reproductive episodes where their substance-use significantly increased, two respondents (Heather and Joyce) linked substance-use to caring for difficult or chronically-ill children and several respondents linked increased substance-use to bereavement or separation. It seems plausible that in all these cases this increase is at least partly explicable by the concept of role strain.

The concept of role strain is relevant both in terms of substances being used to facilitate adult relationships, and to assist childcare. Thus substances can generally be seen as protecting family relationships by managing anger and other negative emotions. This function has previously been identified in studies of women using tranquillisers. As one woman described it (Cooperstock and Lennard, 1979:232):

‘I take it to protect the family from my irritability ... I don’t think it’s fair for me to start yelling at [the children] because their normal activity is bothering me. ... So I take the Valium to keep me calm ... When I blow my top I am told to settle down. When [my husband] does it, it’s perfectly alright ... He can blow but I can’t. And this I have resented over the years ... One of these days I’m going to leave the whole kit and kaboodle and walk out on him. Then maybe I won’t need any more Valium.’

The functions of substances to help women deal with the difficulties of everyday life, to help suppress the emotional pain of trauma, to facilitate adult relationships, and to assist task performance in housework and childrearing can all be seen as aspects of what Graham (1984b, 1987b, 1993a), in reference to cigarette-use among women, has termed 'coping and caring'. Psychological as well as sociological research indicates that women tend to rely on cigarettes more than men do, to maintain their self-confidence and cope with stress (Dickens, 1982), and Graham has identified cigarette-use as one strategy by which mothers cope with caring, including coping with the crises brought on by illness, new babies, unemployment, or poverty. Coping depends upon:

'a number of tried-and-tested strategies which provide the carer with a way of surviving conflicts and shortages on her own. ... Ideally, they are measures which can enable mothers to cope with stress without leaving the room. ... Yet, many of these strategies offer a contradictory kind of support: helping and hurting the family at the same time. Although health-sustaining, coping strategies tend also to be health-threatening. By enabling the carer to cope, they appear to promote family welfare; but only by undermining individual health.' (1984b:170)

For Graham, both cigarettes and tranquillisers can be viewed as strategies which enable 'the carer to remain calm in a situation where resources are few and responsibilities are many.' (1984b:172). Jacobson (1981:32, emphasis in original) similarly describes how cigarettes can be used by women 'as a safety valve, an alternative to letting off steam. They smoke not to accompany expressions of

frustration and anxiety, but *instead of expressing these feelings.*' Thus, for mothers who need to continue caring under stress, without resorting to expressing frustration in a way which might lead to physical abuse of their children, Graham (1984b:173) concludes: 'Actions deemed irresponsible by professionals may be the only means by which mothers can act responsibly.'

In terms of benzodiazepine-use rather than cigarettes, Ettorre and Riska (1995:104) describe a similar function of maintaining self-control, for example by the way in which regular long-term drug-use 'helps to create a sense of routine and order' in the management of stress and unhappiness. Again, the use of benzodiazepines as a strategy for coping and self-control can be shown by Gabe and Thorogood's (1986) identification of benzodiazepine-use as a 'lifeline', taken regularly and depended on in the face of chronic, unresolved problems, and as a 'standby', kept in reserve for a short-lived crisis. I would further add that psychoactive substances generally may also be used to suppress and disguise the effects of intense trauma, such as childhood sexual abuse, and thus may be an effective lay remedy for dealing with undiagnosed post-traumatic stress disorder.

Ultimately, the functions of substance-use which have been identified in this chapter are open to women rather than men because of social expectations that women will be able to perform their roles as partners and mothers competently (Graham, 1987b); cultural and societal expectations about the differential manifestations of depression and distress among women and men (Miles, 1991), so that misery among women is liable to manifest as illness rather than anti-social acts of rage (Littlewood and Lipsedge, 1987); and that when women can no longer perform their roles adequately and when they manifest distress that this is more

likely to be regarded as 'depression' and 'illness' and to be treated with anti-depressants and other medical drugs. It is no surprise that women tranquilliser-users tend to perceive their doctors as endorsing their use of tranquillisers (Prather, 1990; Ettorre and Riska, 1995).

Even where their use of substances is illicit or socially disapproved, the fact that many women nevertheless choose to turn to substances to assist them in achieving pleasure, in managing their moods, in dealing with daily problems and serious trauma, in facilitating relationships within their families and simply in getting their work done demonstrates the level of difficulty some women find in managing the everyday roles demanded of women in contemporary society, and the lengths to which they will go in order to maintain themselves as competent copers and carers.

Chapter Ten: **Implications of the Research for Policy and Theory**

‘Instead of asking “Why is my child a heroin addict, what went wrong in his or her development?” we should, from a sociological perspective, be asking “What is it about this free, liberal, advanced, technological democracy that makes heroin a desirable alternative possible course of action?”’ (Jenks, 1996:43)

Introduction

In the introduction to the thesis, it was argued that substance-using mothers pose a problem for society in two main ways. The first is a pragmatic concern over the mothers’ childrearing abilities, which necessitates clear social policy responses. The second concern relates to contemporary understandings of the general concept of motherhood: this is because, as has been argued in this thesis, to be a substance-using mother is to ‘fracture’ the category of ‘normative mother’ and to run the risk of being expelled into the category of ‘evil mother’. Studying this specific example of substance-using mothers thus permits interrogation of the contemporary social construction of the category of ‘mother’ generally. In order to foreground the conceptual ambiguity and tension of this fracturing process - without sealing off substance-using mothers into one or other of these two opposed categories of either ‘normative’ or ‘evil’ mother - the thesis has employed a third term, ‘problematic mother’, which has assisted the development of an analysis of these mothers’ experiences and perceptions.

While the thesis is primarily a study of contemporary social understandings of mothering, rather than of substance-use, the issue of substance-use is also explored for the light it is able to throw on the social construction of women as mothers, within a patriarchal construction of women’s roles and femininity more generally, such as the expectations of female dependency (Perry, 1979) and emotional

expressivity (Cooperstock, 1971).

The study has used grounded-theory techniques to analyse data gathered, with the aid of a range of research instruments, from fifty-four individuals, including forty-eight women substance-users, five partners and one mother of a substance-using mother. The originality of this study derives from four main aspects, which are, firstly, that a full range of psychoactive substance-use has been studied, with attention being paid to cigarette-smoking, alcohol, prescribed medication such as tranquillisers and sleeping pills, amphetamine, opiates, crack-cocaine, Ecstasy, LSD, and inhalant gas. Secondly, the interview sample comprises a highly heterogeneous group, ranging in age from 20 to 59 years old, and including seven grandmothers, with a very wide range of lifestyles and experiences represented. Thirdly, the study is unprecedented in the amount of detail it provides on the women's own childhood experiences and the social milieu in which they currently mother. The fourth original aspect of the study is that the theoretical focus of the study, on motherhood rather than on substance-use, has provided the opportunity of a new look at both substance-users and mothers, since previous studies of substance-users were not able to investigate motherhood in such depth (Rosenbaum, 1981a; Colten, 1982; Taylor, 1993; Lewis et al, 1995) and previous studies of motherhood (with the exception of Graham, 1976, 1993a, focusing on cigarette-smoking) have used samples of non-substance-dependent mothers (for example, see Breen, 1975; Rich, 1977; Dally, 1978; Gordon, 1978; Oakley, 1979; Badinter, 1981; Boulton, 1983; Ruddick, 1990; Glenn et al, 1994; Ribbens, 1994). These four aspects together have enabled the study to go beyond the conceptual constraints of other substance-use research and to begin to move below the surface

of the women's lives into the realm of their 'hidden accounts' of emotional pain and sense of failure as 'problematic mothers'. This is a realm where, as the usual narrative accounts of mothering begin to grow threadbare and unravel, it is possible to observe the actual warp and weft of mothering, its essential everyday components bare of many of the normal supports that surround motherhood, such as kin ties, stable housing, and a non-stigmatised lifestyle.

The focus of this chapter is on the concept of control, and the respondents' efforts to take and maintain control, within the broad framework of the four questions raised in Chapter One, on substance-using mothers' childhoods, social context, relationships with their children, and understandings of the functions which substances play in their lives. Some of the implications for social policy responses are discussed, and the chapter then takes the discussion further by examining the concept of 'problematic motherhood' more closely, in order to draw out some implications of this thesis for the development of sociological understandings of motherhood and substance-use.

Taking control, losing control: policy implications

This thesis has not only examined substance-using women's own experiences and perceptions around motherhood, but it has also documented societal reactions to them - reactions which provide the context within which the women live out their substance-taking and mothering roles, and within which policy concerning them is constructed and developed. Chapter One illustrated this issue with the example of media reactions to the heroin-dependent mother of a murdered five-year-old, Dillon Hull, in which the mother was presented by the media as having failed to protect her child adequately and thus carried the major portion of blame for the

child's death, despite the fact that it was the father and not the mother who was present when the child was murdered, and the murder appeared to have been committed in connection with drug debts incurred by the father.

In Chapter Four, examples from the media were again used, this time to illustrate how a substance-using mother's immediate kin network - typically the woman's own mother - can be viewed, and may view themselves, as salvaging their grandchildren from the depredations inflicted by the mother, again presented as failing to protect her children adequately. This issue of inadequate protection was demonstrated also in the discussion of the research data, notably in Chapter Eight, where protection was seen to be a key dimension of mothering, but one dependent on access to levels of personal power and resources often beyond the reach of substance-using mothers. Nevertheless, as was also shown from the research data and from the evidence of other studies (Rosenbaum, 1981a, 1981b; Colten, 1982; Taylor, 1993; Kearney et al, 1994), substance-using mothers tend to value conventional and traditional notions of motherhood, and feel acutely any failure in this 'master status', a response which may be heightened by their emotional investment in their relationship with their children *vis a vis* their adult partners.

Policies and practice directed at women substance-users need to take greater account of the high rates of trauma experienced in childhood and specifically the permanently damaged relationships with their mothers which may result from this trauma. This has implications for any policies aimed at encouraging the role of grandparents in taking over the care of their grandchildren, since mothers, already caught up in a tangle of emotions with their own mothers and now experiencing the erosion of their own mothering 'master status' (Becker, 1963a) and perhaps

also resenting and fearing encroachment on their primary love-relationship (Beck, 1992) with their children, may find themselves stranded in a minefield of incandescent pain as they fail simultaneously both at being daughters and being mothers, as their own mother becomes the ‘good mother’ and they themselves become labelled and rejected as the ‘evil mother’.

Equally, policies aimed at encouraging adoption of young children in preference to repeated episodes of local authority care, while perhaps not activating the same morass of emotions as informal care by the mother’s own family, will still send a similar message that, while her children deserve rescuing, the mother herself is beyond help and is being ‘written off’. While it is the case that ‘absentee mothers’ are an all but invisible group in the social science literature (West and Kissman, 1991), one study of mothers relinquishing children for adoption (Howe et al, 1992) has demonstrated that many women suffered grief, guilt and loss of self-esteem for decades afterwards. An American study of substance-using mothers whose newborn children were taken into care (Raskin, 1992: 149) noted that loss of custody of a child ‘is at once both the loss of a loved person and the loss of an abstraction. One loses one’s baby or child(ren) and one’s ideal image of oneself as a competent mother.’

The emotional cost of relinquishing one’s child to the care of another should not be underestimated. Even to leave one’s children in the care of the birth father may feel intensely painful: as one mother (Guardian, 1992:12) expressed it: ‘my sense of loss felt like the psychological equivalent of being flayed alive. And compounding the pain came the guilt, because on our common-sense scale of human wickedness, mothers leaving their kids rate pretty low.’ This is becoming an increasingly

common scenario, as many mothers find themselves embroiled in custody disputes and having to negotiate their status as ‘good mothers’ (Lewin, 1990) in a legal climate which tends increasingly to favour the parental rights of fathers (Smart, 1991) while remaining reluctant to hold fathers rather than mothers culpable when things go wrong (Milner, 1993; O’Hagan and Dillenburg, 1995). As discussed in Chapter Four, current social policy towards mothers who are seen as failing is informed by ideologies of ‘delinquency’ necessitating rescue and of a ‘cycle of deprivation’ necessitating rehabilitation, and by the more recent ideology of the single mother as the motor driving the reproduction of an under-socialised urban underclass, necessitating separation of mother and child through voluntary or involuntary adoption procedures. Through whatever channels separation is effected, the non-custodial mother is left with the task of re-defining both her remaining role in her children’s lives (if any) and her own, new social role as simultaneously mother and not-mother. This process of negotiating a new role was illustrated in Chapter Six, with the examples of Anita and Cathy, who demonstrated the category of ‘problematic mother’, as they struggled with contesting their eviction out of the category of normative ‘good mother’ into the painful conceptual ambiguity of being ‘a freak’, ‘a bad uncaring person’ and ‘different from the rest of the people’. Mary Douglas’ work on categorisation (1966, 1992) has illustrated the powerful social drive which exists to demarcate clear conceptual boundaries and, as a consequence of this, the societal lack of tolerance for ambiguous or interstitial categories and roles, which quickly become ‘taboo’, associated with pollution, dirt and evil. ‘Problematic mother’, as an ambiguous social category, slips and slides on the border of ‘evil mother’ and

women may deal with the discomfort of inhabiting this indeterminate category by attempting, as Cathy did, to ‘pass’ (Goffman, 1968) as a non-mother. They may also increase their substance-use as a coping strategy; rapidly become pregnant again in order to restore the normality of legitimately inhabiting the mother status; or exhibit emotional detachment from any subsequent children in self-defence against the pain of further possible traumatic loss (Raskin, 1992).

When, as is the case for the majority of substance-using mothers, children do remain in the family home, there are a range of other issues which may arise, affecting the women’s ability to maintain control of their family-life. For example, as discussed in Chapter Six, the social and economic context within which women mother significantly affects their experiences. For many non-substance-using mothers, the socioeconomic context of their daily lives can, through the wider kin network for example (Graham 1985a, Wilmott, 1987; Bradshaw and Holmes, 1989; Craig and Glendinning, 1990; Ritchie, 1990) provide assistance in helping them to build and maintain a ‘normal’ family life, that is, one in which the family unit is secure from any outside interventions which would threaten the very integrity of the unit. However, the research data suggested, on the contrary, that for this sample of mothers their socioeconomic context tends to militate against their ability to build a secure family life and that, where their social context can be seen as more enabling of their family life, this tends to be through non-mainstream activities such as involvement in acquisitive crime. Barriers to the women being able to establish effective and cohesive family units include their fragile economic position (especially if, as is often the case, they live with a male partner who controls the finances without taking responsibility for running the household);

domestic violence; break-up of the family home and separation of mother and children; and the women's lifestyles as petty criminals. Alongside these challenges to their ability to exert control over their lives and their substance-use are the equally exigent but more subtle pressures of inhabiting the discreditable status of 'junkie' or 'alcoholic'. As with losing custody of their children, the thesis has argued that the status of 'junkie' or 'alcoholic' attenuated the women's ability to inhabit the status of 'good mother' and placed them at risk of expulsion into the category of 'evil mother'. Thus respondents such as Beth, Carrie and Geraldine found themselves in the ambiguous category of 'problematic mother', where they struggled tenaciously to justify continuing legitimate inhabitation of 'good mother' status and disavowed their status as a 'junkie' or 'alcoholic', for example claiming, as Beth did:

'I think you've got junkies and you've got junkies, if you want to put it in a term. Because you've got some got some real down and out junkies -- And you've got people that use because they've got a habit -- And I think I'd put myself in the second category. I like to keep the kids and that tidy. I think you've got to maintain respect for yourself and the children.' (011:10-11)

Alongside the discrediting effects of substance-use, which contributed to the respondents' sense of losing control, were the seven positive functions of substance-use identified in Chapter Nine, which were regarded by the respondents as helping them maintain control. These identified functions are based around the concept of the use of psychoactive substances as a coping strategy enabling maintenance of the women's caring and relational roles, which suggests that

continued use of psychoactive substances is a rational choice on the part of the women until such time as more beneficial coping strategies are available to them. For example, respondents found substances helped them cope with tiredness and depression, both common problems among mothers (Brown and Harris, 1978; Popay, 1992; Ball, 1994).

The Government is increasingly concerned over the issue of drug-using parents, particularly since there are now around 200,000 homes in Britain with a drug-dependent parent (Guardian, 1998a), a figure which does not include those homes with an alcohol-dependent parent. Numbers of women using psychoactive substances are also rising, especially among those of childbearing age (ISDD, 1996, Alcohol Concern, 1997). Thus all the issues raised in this thesis will be of growing relevance to policy-makers, who must take account of changes and developments in societal responses, such as the increasing move towards adoption (Guardian, 1999), mobilisation of substance-dependent women's parents to care for the women's offspring (Guardian, 1998a), and the willingness on the part of the media - from the popular press (Daily Mail, 1997) to academic literature (Sturmer et al, 1991) - to stigmatise substance-using mothers and portray them as culpable 'evil mothers' who fail to protect their children. Policy-makers also need to take account of the wider socioeconomic context which presents barriers to women substance-users' ability to be able effectively to take and maintain control of their family-lives, such as the lack of control over material resources and lack of control even over their own bodily integrity if they live in circumstances of domestic violence. Again, policy-makers need to be aware of factors within the women's family of origin, such as childhood sexual abuse, which militate against the women

being able to access help from their kin network and which not only fail to provide successful role-models of motherhood but also result in the women lacking confidence, as adults, in their own mothering ability, having experienced what Rich (1977: 225) has termed being ‘wildly unmothered’, including in some cases lack of protection from sexual or physical abuse. Rich (1977:243-4), as quoted in Chapter Five, has described some of the effects of such mothering under patriarchy:

‘Many daughters live in rage at their mothers for having accepted, too readily and passively, “whatever comes”. A mother’s victimization does not merely humiliate her, it mutilates the daughter who watches her for clues as to what it means to be a woman. ... a daughter [is likely] to feel rage at her mother’s powerlessness or lack of struggle - because of her intense identification and because in order to fight for herself she needs first to have been both loved and fought for.’

The following section now examines in more depth some of the broader issues related to mothering under patriarchy, and how ‘problematic motherhood’ can throw light on the social expectations of normative motherhood.

Taking control, losing control: mothering under patriarchy: theoretical implications

Early studies on women using illicit substances drew attention to the way in which women’s drug-use ‘funnelled’ them into social deviance (Rosenbaum, 1981a) where they nevertheless continued to adhere to normative notions of conventional motherhood (Rosenbaum, 1979, 1981a; Colten, 1982). More recent research has

laid less stress on their deviance and greater emphasis on their similarities to non-drug-dependent women, their competence as ‘rational actors’ (Taylor, 1993), their strategies to protect their mothering abilities (Kearney et al, 1994) and their positive enjoyment of psychoactive substances (Henderson, 1994a, 1994b).

Meanwhile, Perry (1979) laid the groundwork for understanding substance-dependency as a paradoxical form of normative female dependency under patriarchy, which can be illustrated for example by Cooperstock’s (1971) explanation of women’s tranquilliser-use as enabling the management of role-strain, or Graham’s (1993) explanation of mothers’ smoking as again enabling the management of role-strain, this time in terms of coping with domestic caring responsibilities under conditions of poverty. Ettore and Riska (1995:154) have extended the discussion on dependency, by showing how women’s tranquilliser-dependency ties into the institution of gender which ‘channels women into being dependent by having others dependent on them’.

This dual dependency identified by Ettorre and Riska is paradoxical, but it highlights yet another paradox as well, since women’s functional use of dependency-forming substances in order to manage their relationships (and their distress arising from these relationships) reveals a central tension within normative feminine dependency, in which dependent passivity and conformity to patriarchal expectations is produced only through the women’s active strategies of self-control and self-management. However, to attempt to take control and to cope by using substances is again a problematic form of control, since by definition coping by dependency on psychoactive substances is *not* coping. Such paradoxes are at the heart of the respondents’ ambivalent and uncomfortable status as ‘reluctant non-

conformists', as they subscribe to traditional mainstream notions of mothers as 'copers' (Graham, 1982) while finding themselves unable to live up to this ideal.

Ettorre and Riska (1995) identified a key problematic in contemporary Western society as that of 'self control'. Foucault (1977) has argued that modern forms of social control have led to a greater emphasis on self-surveillance and self-control, and this notion, while not explored in gendered terms by Foucault himself, is one familiar to feminists who have long emphasised the greater levels of control exercised over, and demanded of, women under patriarchy. For example, Oakley (1981) has discussed how 'normal motherhood' can be analysed as 'an exercise in self-control', and Graham's (1982) view of motherhood as self-effacing 'coping' can be seen as one example of mothers being expected to be constantly 'in control' of their required task-performance. The concept of 'control' can thus be seen to have many dimensions, all of which are arguably harder for women to achieve than men, within a patriarchal context. For example, taking control of one's own physical bodily integrity is a very basic level of control, but one which can be challenged by women's lack of self-determination over their reproductive functions, over their sexuality, over their physical safety, and one which may also be compromised by gendered responses to distress, such as women's greater levels of self-harm and eating disorders. On whatever dimension control is considered - whether it is taken as being in control of one's moods and emotions, having the freedom to express oneself, freedom from fear and threat, freedom to pursue valued goals, protection of privacy and personal space, economic autonomy, or the ability to hold down a job and fit into mainstream society - women are likely to find their ability to exercise control more circumscribed than their male counterparts.

Given that non-substance-using women may find it difficult to take control of their everyday lives, what is remarkable is not that substance-using mothers find taking control so problematic, but that they are sometimes able to succeed, and that where they do lose control they struggle so determinedly to regain control, to the benefit of themselves and their families.

The relationship between substance-use and self-control has several dimensions. Women may use substances as a pleasurable expression of autonomy, reinforcing their sense of control over their life. Among the respondents in this sample, Hilary and Mandy represented this view. They had both previously been dependent on amphetamine, but now used cannabis, amphetamine and Ecstasy recreationally and derived a sense of enjoyment, competence and expertise from their drug-use.

Other respondents used substances when they felt able to control their external life, such as their occupation, but not their internal private life. As Dilys, a binge-drinker, disclosed (027a:10):

‘it never affected my work. I was a completely different person. I was completely in control at work. -- And yet walking out, once you walked out there and walked in the doors it was completely shatter - Totally, uh, out of control, I had no control over my life at all. My private life was in tatters sort of thing. -- [At work] I left sort of *me* outside the gates. Or any personal feelings or anything, I left them all completely outside. I could forget about everything until I came in my door again.’

Unlike Dilys, other respondents felt that there was no aspect of their external

environment which they were able to control, and controlling their perceptual state then became the only form of control they could exert. Thus Anita discussed how she usually rigidly controlled her own eating and drug-taking but, when her partner insisted on feeding her and regulating her drug-intake (and also controlled her body through coercive sexual acts and monitoring her absences from home), she felt the only form of control left to her was to steal extra amounts of drugs from her partner in order to retain a sense, however minor, of autonomy and choice.

Alongside more public dimensions such as economic status, taking and losing control is closely linked, for women in particular, with emotional states. Ettorre and Riska (1995: 115-6) note that ‘despair, stress and anxiety are operational signs of not being in control of one’s life’ and this lack of emotional control has historically been associated with women more than men. Higher levels of unhappiness may perhaps be linked to the fact that women, more than men, tend to experience relationships as more salient in their lives, thus exposing women to greater levels of worry and distress over intimate relationships than their (generally male) partners experience. To some extent, as already discussed, mothers may turn to their relationships with their children in preference to adult males, and this may help to buffer them from emotional pain. However, their relationships not only with their adult partners but also with their children may be fraught with difficulty, as was shown in Chapters Five, Seven and Eight. Painful experiences of their mothers’ powerless responsibility in their own childhoods may affect their own mothering abilities, and powerless responsibility is also likely to be a significant issue in their own experience of mothering, as high societal expectations on mothers combine with the conceptual ambiguity and invisibility of fathers to place

heavy demands on mothers to be ‘continually and ultimately responsible for the health, development and happiness of their children’ (Hughes et al,1980:26). This level of responsibility often goes hand-in-hand with lack of access to the personal power and resources that would enable the responsibility to be effectively practised, thus trapping mothers into a no-win situation.

This sense of powerless responsibility becomes particularly acute when the issue of protection of their children arises: perhaps it is this, ultimately, which marks out the substance-using mother as a ‘problematic mother’, one vulnerable to eviction into the category of ‘evil mother’. Maternal protection is a key function precisely because it is one of the hidden mechanisms by which patriarchy is able to be sustained.

As feminists in the 1970s identified within the phenomenon of rape a central paradox of patriarchy - that women are taught to look to men for protection against sexual aggression by men (Brownmiller, 1975) - so also the phenomenon of maternal protection can be regarded as a paradox, or what Daly (1979) has termed a ‘patriarchal reversal’, in that, by invisibly taking on the work of protecting children from male violence and predation, mothers allow the patriarchal myth to be maintained that it is men who protect women and children. For example, women’s knowledge of the widespread sexual abuse of children by men is, by this process, kept at the level of shameful secrets and ‘hidden accounts’, where sexual abusers are conceptually segregated as the inexplicable and alien Other, the ‘paedophile’ or ‘child molester’ rather than understood as an inevitable by-product of patriarchal male social conditioning, and women’s accounts of abuse are contested as a form of ‘false memory’ (Masson, 1984; Grant, 1993; Butler, 1994;

Orbach, 1994), to enable the community to continue to be deaf and blind to the reality of patriarchal violence.

This protective work of mothers, as with much of their ‘emotional housework’ (Bell, 1990; Bertaux and Delacroix, 1992; Duncombe and Marsden, 1993; Ribbens, 1994) and ‘coping’ generally (Graham, 1982, 1983, 1984b, 1985b), must be kept below the level of usual conscious awareness in order to maintain the myth that the typical patriarchal male poses no threat but rather offers only benign protection. After all, if it was openly acknowledged that mothers do such work, it would become obvious that one of the central planks of patriarchy - the strategy of relying on men for protection against men - is not only illogical but also quite often tragically ineffective.

‘Junkie mothers’, and other ‘problematic mothers’, insofar as they fail to maintain this seamless and invisible coping and protection, threaten to expose this myth. By allowing normative motherhood to unravel and reveal the work of protection within the everyday texture of mothering, ‘problematic mothers’ risk exposing the work that all mothers do. This accounts for much of the ferocity of the response against them, in which they are ostracised into the category of ‘evil mother’. They have failed to protect their children from predation by males, but they have also failed to protect us from having to know about male predation. Thus it is the *mothers* who are blamed in these instances, not the men. It is the mother of Dillon Hull who was held to blame for her son’s death, just as it was the mothers of Maria Colwell, Kimberley Carlisle, Jasmine Beckford and other murdered children who were blamed (Parton, 1991), although in each case it was a man, typically the father or stepfather, who had murdered them. In the case of the respondents in this

study, three children in this sample had been murdered, two by a male arsonist with a grudge against the mother and one by the child's father: several further babies (approximately ten) had died *in utero* as a result of violence, usually by the male partner but in one case by a female neighbour. In addition, in at least four cases respondents believed or knew their children had been sexually abused. All these episodes had occurred in situations where the mothers were themselves vulnerable and had been the victims of severe violence from men, and in a context of institutionalised lack of interest from the police, who disregarded pleas for help and in some cases even assisted male assailants to gain access to the women, for example by handing over a respondent's front-door keys to her abusive boyfriend. Nevertheless the mothers, as with society generally, held themselves responsible for what occurred.

In the final analysis therefore, this thesis has argued that substance-using mothers are 'problematic mothers' because they often find themselves 'wildly unmothered' in their own childhoods, alienated from other women including their own mothers, and only with difficulty establishing themselves as effective mothers in adult life; they are often unable to take control and maintain the integrity of themselves and their family-lives against outside forces of dissolution, and this leads them into a form of reluctant non-conformity with maternal norms, and an experience of powerless responsibility as they attempt to protect their children from the consequences of their lifestyles.

Thus, to answer Jenks' question, posed at the opening of this chapter, we can reply that the dependent use of heroin, or any psychoactive substance, can be viewed as

a desirable course of action for mothers under patriarchy because it is one way of assisting them to maintain a sense of control in a context of powerless responsibility.

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